

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14097

## CERTIFICATE OF DEATH

Reg. Dist. No.

13976

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ohio</i>		b. COUNTY <i>Greene</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural- Adelphi</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Zenia</i>		d. STREET ADDRESS <i>72 x. 3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Paint Branch Nursing Home</i>				d. STREET ADDRESS <i>135 Dayton Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Warren</i>	Middle <i>Clark</i>	Last <i>Allen</i>	DATE OF DEATH	Month <i>Dec.</i>	Day <i>9</i>	Year <i>1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>Feb. 24, 1873</i>	9. AGE (In years lost birthday) <i>86 yrs.</i>	IF UNDER 1 YEAR Months <i>8</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i>		11. BIRTHPLACE (State or foreign country) <i>West Chester, Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Levi E Allen</i>		14. MOTHER'S MAIDEN NAME <i>Alice Denman</i>		Address <i>Paint Branch Nursing Home Records</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>							
16. SOCIAL SECURITY NO.							
17. INFORMANT							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis, Generalized</i> DUE TO <i>450.0</i> Conditions, if any, which gove rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Prostatic hypertrophy with Urinary Retention</i>							
INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs +</i>							
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 2201 Carroll Ave</i>	20f. (City or town) <i>WILLA M.</i>	(County) <i>TX</i>	(State) <i>Kansas City</i>	
21. I certify that I attended the deceased from <i>Nov 9, 1959</i> , to <i>Dec 9, 1959</i> , that I last saw the deceased alive on <i>Dec 6, 1959</i> , and that death occurred at <i>WILLA M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>J.W. Whiting MD</i> ADDRESS (Street, city or town, state) <i>2201 Carroll Ave</i> DATE SIGNED <i>12-9-59</i>							
PHYSICIAN'S NAME (Type) <i>James W. Whiting MD</i>		22b. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL 12-10-59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>WOODLAND CEMETERY XENIA</i>		22d. LOCATION (City, town, or county) <i>OHIO</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jos. Hawley's Sons Inc.</i>		ADDRESS <i>1756 Pa. Ave. NW</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 11 '59</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Kline</i>	

ST. CROWLEY'S-NEW YORK FEDERAL BUREAU OF INVESTIGATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13977

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Prince Geo.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>RURAL</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7522 Jackson Ave.</i>		d. STREET ADDRESS <i>7522 Jackson Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Iena</i>	Middle <i>(Ami)</i>	Last <i>ANDERSON</i>	4. DATE OF DEATH Month <i>DEC</i>	Month <i>31</i>	Day <i>1959</i>	Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>29 Dec 1879</i>	9. AGE (In years lost birthday) <i>80 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Sweden</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Unknown</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>— — —</i>			17. INFORMANT <i>Mr. Ernest J. Wolfe</i> Address <i>7522 Jackson Ave.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Dec 14, 1959</i> , to <i>Dec 31, 1959</i> , that I last saw the deceased alive on <i>Dec 30, 1959</i> , and that death occurred at <i>2 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>O. Blitze</i>		ADDRESS (Street, city or town, state) <i>6911 5th Street, NW, DC</i>						
PHYSICIAN'S NAME (Type) <i>A. B. Little, MD</i>		DATE SIGNED <i>12/31/59</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>31 Dec 1959</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Lee's Crematory</i>		22d. LOCATION (City, town, or county) (State) <i>Wash., DC</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home 47 Maryland Ave. NE</i>		ADDRESS <i>Lee Funeral Home 47 Maryland Ave. NE</i>		24a. REC'D BY REGISTRAR DATE JAN 4 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13978					
14098 CERTIFICATE OF DEATH										Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>VIRGINIA</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ALEXANDRIA</b> d. STREET ADDRESS <b>1614 SHELDON DRIVE</b>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>21 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>LENA</b>		Middle <b>B</b>		Lost <b>ANDERSON</b>		4. DATE OF DEATH <b>DECEMBER</b>		Month	Day	Year			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1 SEPTEMBER 1922</b>		9. AGE (In years lost birthday) <b>37 yrs.</b>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>				11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>				12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
13. FATHER'S NAME <b>GADDY MOORE</b>					14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		INFORMANT <b>JAMES O ANDERSON (HUSBAND)</b>		Address <b>1614 Sheldon Dr Alexandria, Virginia</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PRESPIRA TORY FAILURE</b> DUE TO 193.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) <b>Astrocytoma CEREBRUM</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)										INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>8 MOS</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I attended the deceased from <b>20 DECEMBER, 19 59</b> , to <b>21 DECEMBER, 19 59</b> , that I last saw the deceased alive on <b>21 DECEMBER, 19 59</b> , and that death occurred at <b>0235A</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>USAF HOSPITAL ANDREWS</b> M.D. <b>REGINALD P. MC MANUS, CAPT USAF, MC</b> <b>USAF HOSPITAL ANDREWS, WASH 25, DC</b> DATE SIGNED <b>21 DECEMBER 59</b>													
ACTUAL SIGNATURE <i>Reginald P. Mc Manus</i>															
PHYSICIAN'S NAME (Type) <b>REGINALD P. MC MANUS, CAPT USAF, MC</b>															
22a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/24/1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedardale Cemetery</b>		22d. LOCATION (City, town, or county) <b>Mullins, So. Carolina</b>		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Douglas L. Mulloff</i>		ADDRESS <b>Fit 3 Service Funeral Home 3245 Wilson Blvd. Arlington Va</b>		24a. REC'D BY REGISTRAR <b>DATE DEC 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>									

ST. MARYS RIVER - HIGHLIGHTS OF THE  
WATERFOWL SEASIDE

ST. MARYS RIVER TRAIL

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EVENS GULF

STATE CERT

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13973

14022

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE	
<i>Prince George</i> <i>MARYLAND</i>		<i>Maryland</i> <i>Prince George</i> <i>County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Laurie</i>		<i>8 mos</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
<i>433 Main Street</i>		<i>433 Main St</i>	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Margaret Louise Arnold</i>			
4. LAST NAME		Last	5. DATE OF DEATH
			<i>December 13 1959</i>
6. SEX		7. COLOR OR RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<i>F</i>		<i>W</i>	<i>WIDOWED <input checked="" type="checkbox"/></i>
9. AGE (In years lost birthday) yrs.		10. DATE OF BIRTH	11. IF UNDER 1 YEAR IF UNDER 24 HRS.
<i>87</i>		<i>Oct 28 1872</i>	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Housewife</i>		<i>Name</i>	<i>Glenely Md</i>
12. CITIZEN OF WHAT COUNTRY		<i>USA</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Thomas Sheppard</i>		<i>Ruth Ellen Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
<i>No</i>			<i>Mrs Samuel Arnold, Laurie Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address <i>433 Main St, Laurie Md</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i>	
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		<i>Arteriosclerotic C-V-Pis.</i>	
(b) DUE TO Glu. Arterosclerosis		<i>20 yrs</i>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <i>3/19</i> , 19 <i>39</i> , to <i>12/13</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12/9</i> , 19 <i>59</i> , and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Laurie Md 12/14/59</i>	
ACTUAL SIGNATURE <i>J. M. Warren</i>		DATE SIGNED <i>12/14/59</i>	
PHYSICIAN'S NAME (Type) <i>J. M. WARREN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/15/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Johns Cemetery</i>
22d. LOCATION (City, town, or county) <i>Ellisite City Md</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Danforth, Laurie, Md</i>		24a. REC'D BY REGISTRAR <i>Dec 17 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Adams S. Trahan</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13980

14023

1. PLACE OF DEATH  
a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

## c. LENGTH OF STAY IN 1b

26 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE

Maryland

b. COUNTY

P.H.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Belmont Heights

## d. STREET ADDRESS

5711 Jay St.N.E.

e. IS RESIDENCE ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)First  
Christine

Middle

Last  
Ashton4. DATE  
OF  
DEATH

Dec.

Month  
19Day  
19  
Year  
1959

## 5. SEX

Fem. Negro

## 6. COLOR OR RACE

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

## 8. DATE OF BIRTH

1889

?

9. AGE (In years  
last birthday)  
yrs.

70

IF UNDER 1 YEAR  
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Domestic

## 10b. KIND OF BUSINESS OR INDUSTRY

—

## 11. BIRTHPLACE (State or foreign country)

Md.

## 12. CITIZEN OF WHAT COUNTRY?

Ch. S.A.

## 13. FATHER'S NAME

Unknown

## 14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

(If yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

## INFORMANT

Address

Thomas Ashton, 5711 Jay st NE

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

171X

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

DUE TO

(c)

Carcinomatosis

Carcinoma of Cervix

INTERVAL BETWEEN  
ONSET AND DEATH

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20c. TIME OF INJURY Month, Day, Year  
Hour a. m. p. m.20d. INJURY OCCURRED  
While at work  Not while at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Nov. 23, 1959, to Dec. 19, 1959, that I last saw the deceased alive on Dec. 19, 1959, and that death occurred at 12.30 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

Loren Greco

M.D.

12/19/59

PHYSICIAN'S  
NAME (Type)

Dr. W. Greco

22a. BURIAL CREMATION,  
REMOVAL (Specify)

## 22b. DATE THEREOF

12-23-59

## 22c. NAME OF CEMETERY OR CREMATORIUM

Lincoln Mem

## 22d. LOCATION (City, town, or county)

Brentwood Rd. Md.

(State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

Henry J Washington 4925 Dean Ave #2

## ADDRESS

## 24a. REC'D BY REGISTRAR

DATE DEC 28 '59

## 24b. REGISTRAR'S SIGNATURE

Arthur &amp; Kraus

SEARCHED

INDEXED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG254 1-18-60 et

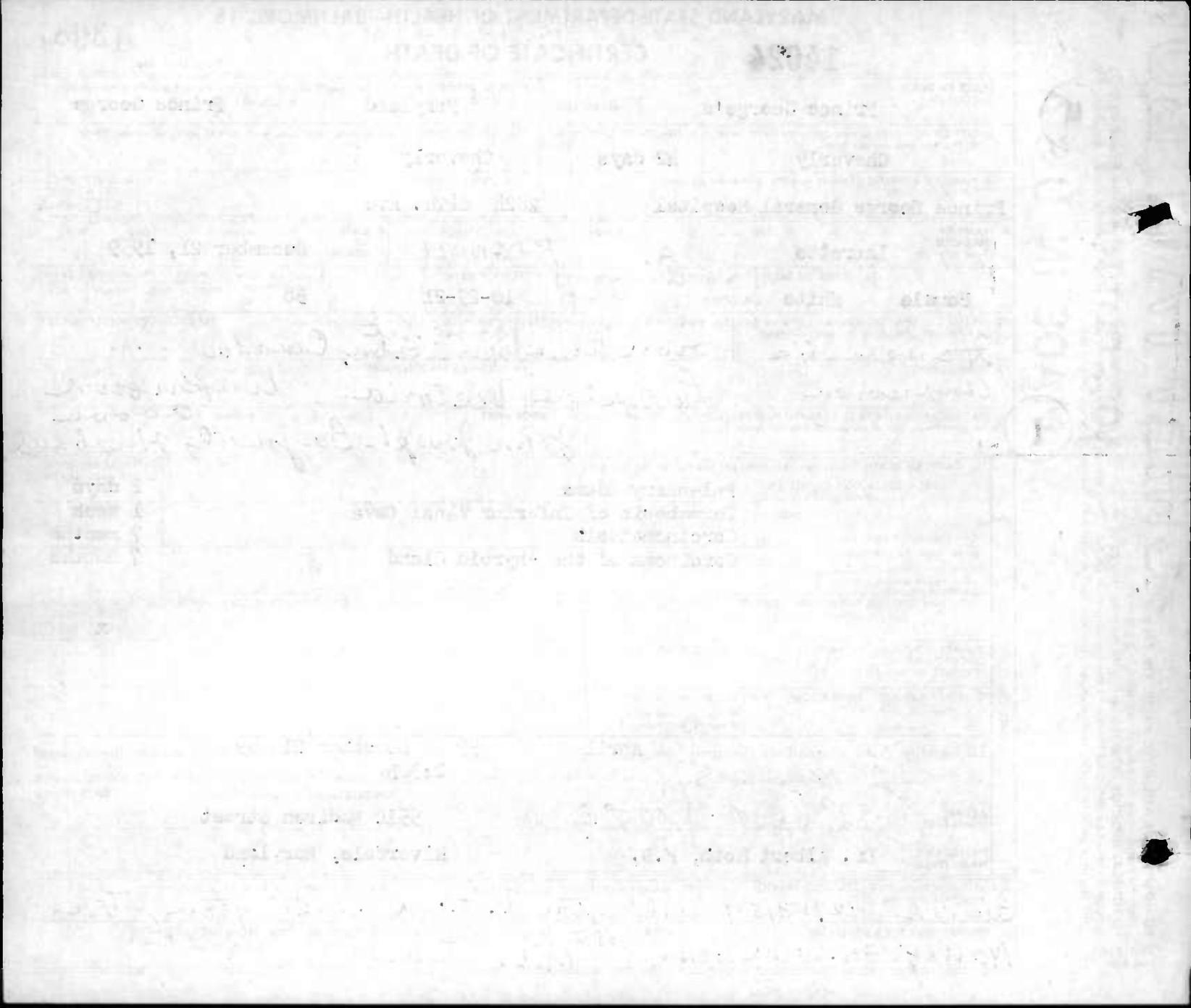
14024

## CERTIFICATE OF DEATH

Reg. Dist. No.

13981

1		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.		X	
1		X	
2		X	
3		X	
4		X	
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 &amp; 9-FilmG251-1/15/60-mb

## CERTIFICATE OF DEATH

Reg. Dist. No.

14370

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>BETHESDA MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	c. LENGTH OF STAY IN 1b	b. COUNTY <b>MARYLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR 4922 Los Altos RD</b>	d. STREET ADDRESS <b>9502 PAGE AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>MR. AL OYSIUS A.</b>	First	Middle	Last
4. DATE OF DEATH <b>DEC. 29 1959</b>	Month	Day	Year
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 7-1885</b>
9. AGE (In years last birthday) <b>86 1/2 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WHEEL RITE WAGON CAPITOL TRANSIT CO.</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		13. FATHER'S NAME <b>SEBASTIAN BAUER</b>	
14. MOTHER'S MAIDEN NAME <b>AMELIA WEIGAND</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>16. SOCIAL SECURITY NO.</b>		17. INFORMANT <b>Sister Agnes Patricia Carroll Manor</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> Arteriosclerotic Heart Disease- DUE TO <b>(c)</b> Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH <b>2 months-</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/6/1958</b> , 19, to <b>12/29/1959</b> , 19, that I last saw the deceased alive on <b>12/28/1959</b> , 19, and that death occurred at <b>12 Neon</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>322-H. Street, N.E.</b>	
ACTUAL SIGNATURE <b>Thomas F. Collins</b>		DATE SIGNED <b>12/29/1959</b>	
PHYSICIAN'S NAME (Type) <b>Thomas F. Collins, M.D.</b>		Washington 2, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 12-31-59</b>		22b. DATE THEREOF <b>Cedar Hill</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) <b>Gaithersburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Timothy Hanlon 3831-Gov. Avenue</b>		24a. REC'D BY REGISTRAR <b>JAN 11 '60</b>	
ADDRESS <b>3831-Gov. Avenue</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13982

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>	c. LENGTH OF STAY IN 1b <i>9 days</i>	b. COUNTY <i>Prince George's</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eugene Island Memorial</i>	d. STREET ADDRESS <i>425 Prince George St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edward</i>	First <i>E</i>	Middle <i>R</i>	Lost <i>Bauer</i>	
4. DATE OF DEATH <i>Dec 2</i>	Month <i>Dec</i>	Day <i>2</i>	Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 30 1878</i>	
9. AGE (In years lost birthday) <i>81 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Photography</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Missouri</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Bauer</i>	14. MOTHER'S MAIDEN NAME <i>Joanne Laumer</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Cecum</i> 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)				
INTERVAL BETWEEN ONSET AND DEATH <i>9 months</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec 30</i> , 1955, to <i>Dec 2</i> , 1959, that I last saw the deceased alive on <i>Dec 2</i> , 1959, and that death occurred at <i>510 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>ROBERT S. MCCENEY M.D.</i> <i>402 MAIN ST.</i> <i>LAUREL, MD.</i>
ACTUAL SIGNATURE <i>Robert S. McCeney</i>		M.D.	DATE SIGNED	
PHYSICIAN'S NAME (Type)				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/5/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn Memorial Park</i>	22d. LOCATION (City, town, or county) <i>Laurel</i>	(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Randolph, Laurel, Md.</i>		ADDRESS <i>DeWitt Randolph, Laurel, Md.</i>	24a. REC'D BY REGISTRAR <i>DEC 7 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13983

1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges'</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		d. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>William Seton Belt</b>		First	Middle	Last	4. DATE OF DEATH <b>December 6, 1959.</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Feb. 14, 1871</b>	9. AGE (In years from birth) <b>88 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>William Seton Belt</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Lee Bowie</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unkwn</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>William Brooke--Upper Marlboro, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Hypertension Cardio-Vascular Renal Disease 2 yrs</b> (c) DUE TO <b>Diabetes Mellitus (mild)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo. 6 days</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Upper Marlboro</b> (State) <b>Md.</b>		
21. I certify that I attended the deceased from <b>July 7, 1957</b> to <b>Dec. 6, 1959</b> , that I last saw the deceased alive on <b>Dec. 4, 1959</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Upper Marlboro, Maryland</b> DATE SIGNED <b>12/7/59</b>				
ACTUAL SIGNATURE <b>James G. Sasscer</b>								
PHYSICIAN'S NAME (Type) <b>James G. Sasscer, M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/9/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Barnabas Cemetery Leeland</b>		22d. LOCATION (City, town, or county) (State) <b>Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Funeral Home-Marlboro, Md.</b>		ADDRESS Upper		24a. REC'D BY REGISTRAR DATE DEC 9 '59		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

WISCONSIN STATE INSURANCE DEPARTMENT - BIRCHWOOD, WI

CERTIFICATE OF DEATH

RECEIVED

RECORDED

SEARCHED

INDEXED

SERIALIZED

FILED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14100 CERTIFICATE OF DEATH

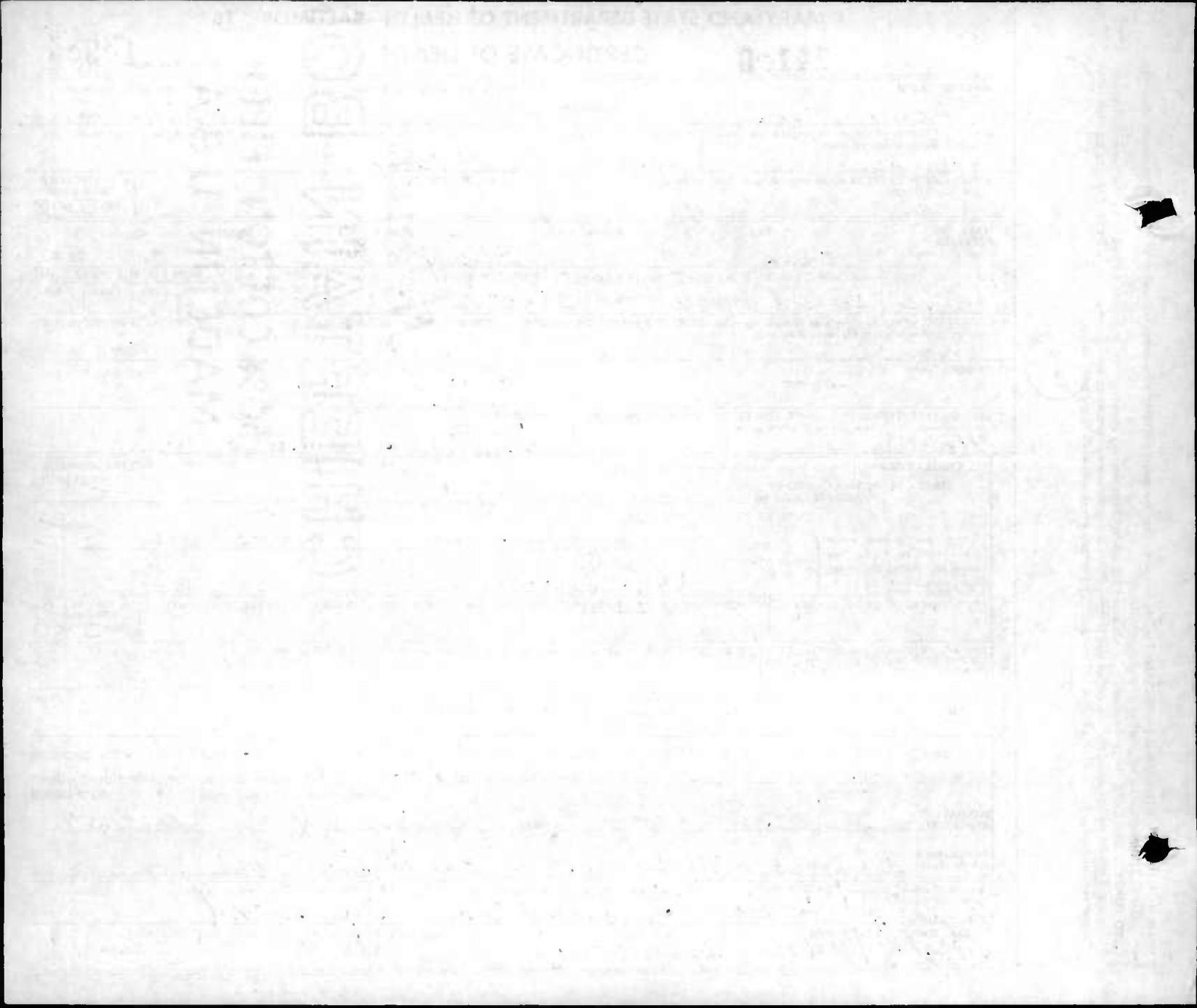
Reg. Dist. No.

13984

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i>		b. COUNTY <i>Prince George</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aquasco</i>		c. LENGTH OF STAY IN 1b <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Aquasco</i>		d. STREET ADDRESS <i>-</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>-</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>ELLA</i>		First	Middle	Last	4. DATE OF DEATH <i>Berry</i>	Month	Day	Year <i>Dec. 30 1959</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 8 1871</i>		9. AGE (In years last birthday) <i>88 yrs.</i>	IF UNDER 1 YEAR <i>88</i>	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>nurse</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>-</i>		14. MOTHER'S MAIDEN NAME <i>Bettie Butler</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		INFORMANT <i>Walter Berry aquasco md</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		DUE TO <i>Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <i>Generalized Cardiac-Vascular Renal Disease</i>						
(c)		<i>Age Progression</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Brandywine, Md</i>		20f. (City or town) <i>Brandywine, Md</i>		(County) <i>Brandywine, Md</i> (State) <i>Md</i>
21. I certify that I attended the deceased from <i>10-10</i> , 19 <i>59</i> , to <i>12-30</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>11-10</i> , 19 <i>59</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Brandywine, Md</i>		DATE SIGNED <i>12-31-59</i>		
ACTUAL SIGNATURE <i>Richard N. Dobson</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>Richard N. Dobson, M.D.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-2-60</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St Phillips Cem.</i>		22d. LOCATION (City, town, or county) <i>Aquasco, Md</i>		(State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>George Nelson</i>		ADDRESS <i>Aquasco, Md</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 6 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

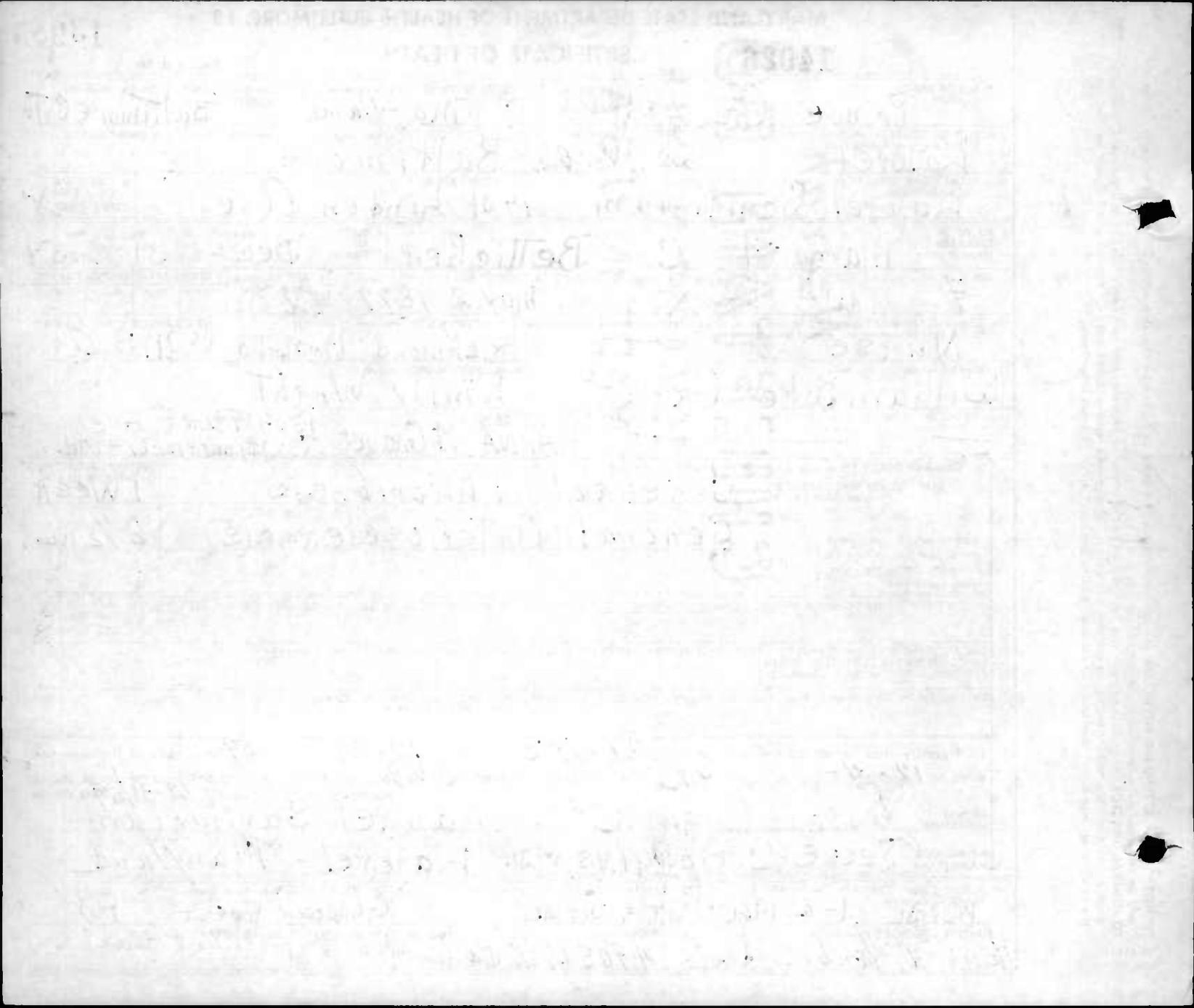
13985

14026

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Prince Georges MARYLAND		Maryland Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb byp. 10 Mo. 206a	
Bauzel		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Vol. -4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1431 Linden Ave.	
Bauzel Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Dec - 31 Year 1959	
Margaret C. Betticher		Month Day	
5. SEX F		6. COLOR OR RACE W.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 2, 1877	
9. AGE (In years last birthday) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse	
11. BIRTHPLACE (State or foreign country) Richmond Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Baker Graves		14. MOTHER'S MAIDEN NAME Emily Wight	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  16. SOCIAL SECURITY NO.  17. INFORMANT ANNA M. Graves 1509 Park Ave Baltimore-17-Mid.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO General Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 6 1/2 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/11/53, 19, to 12-31, 1959, that I last saw the deceased alive on 12-31-, 1959, and that death occurred on 5:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 12-31/59 DATE SIGNED	
ACTUAL SIGNATURE Jesse C. Coggins, M.D.		PHYSICIAN'S NAME (Type) Jesse C. Coggins, M.D. Bauzel Sanitarium	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-4-1960	
22c. NAME OF CEMETERY OR CREMATORIY ST. THOMAS'		22d. LOCATION (City, town, or county) (State) Garrison Forest MD	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins, Son, Co.		ADDRESS 4905 York Rd.	
24a. REC'D BY REGISTRAR JAN 5 '60		24b. REGISTRAR'S SIGNATURE Arthur J. Traas	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**1410 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

13986

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Palmer Park		3 yrs.		Palmer Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
7413 8th Place				7413 8th Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
William Ferdinand Biggs					December 25 19 59
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) IF UNDER 1YEAR IF UNDER 24 HRS.
Male		white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 20, 1877	82 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired screenman		Dist. of Col.,		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William Biggs		Mary V. King		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No.				Walter L. Purvis; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure INTERVAL BETWEEN ONSET AND DEATH					
420.0 DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John T. Maloney		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 28-59		22c. NAME OF CEMETERY OR CREMATORIALy Cedar Hill	
22d. LOCATION (City/town, or county) Baltimore				(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lemmons Bros		ADDRESS 166199 Hope Rd SE		24a. REC'D BY REGISTRAR DEC 28 59 DATE	
24b. REGISTRAR'S SIGNATURE					

THE NATIONAL CIVIL SERVICE COMMISSION - DIVISION OF DEATH  
CERTIFICATE

NAME	ADDRESS	AGE	SEX	DEATH DATE	CAUSE OF DEATH
John Doe	123 Main Street, Anytown, USA	55	M	10/10/1999	Heart Disease
MATERIAL TESTED					
<input type="checkbox"/> Blood					
<input type="checkbox"/> Urine					
<input type="checkbox"/> Hair					
<input type="checkbox"/> Lung Tissue					
<input type="checkbox"/> Heart Tissue					
<input type="checkbox"/> Liver Tissue					
<input type="checkbox"/> Kidney Tissue					
<input type="checkbox"/> Brain Tissue					
<input type="checkbox"/> Other (specify)					
TEST RESULTS					
Blood Test: Negative for alcohol and drugs.					
Urine Test: Negative for alcohol and drugs.					
Lung Tissue Test: Positive for cigarette smoke.					
Heart Tissue Test: Positive for heart disease.					
Liver Tissue Test: Negative for liver damage.					
Kidney Tissue Test: Negative for kidney damage.					
Brain Tissue Test: Negative for brain damage.					
Other Test: (specify)					
NOTES					
This certificate is issued upon the basis of the information provided by the physician or medical examiner.					
Signature: _____ Date: _____					

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

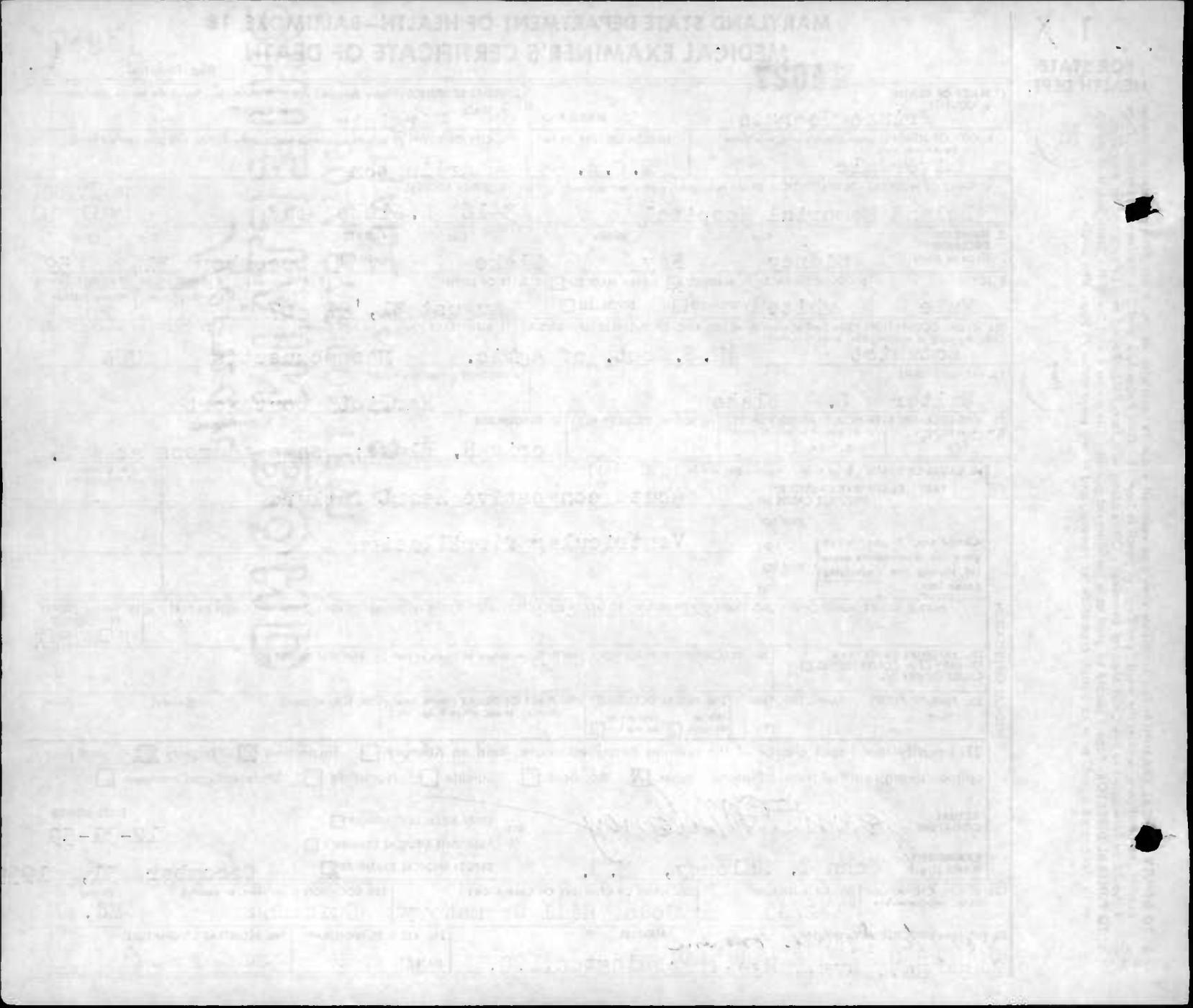
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13987

Reg. Dist. No.

14027

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>D. O. A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>		d. STREET ADDRESS <b>3416 N. Glebe Road</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Sidney Fay Blake</b>		First	Middle	Lost	4. DATE OF DEATH <b>December 31</b>	Month	Day	Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 31, 1926</b>	9. AGE (In years last birthday) <b>67 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Botanist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Dept. of Agric.</b>		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Walter R. Blake</b>				14. MOTHER'S MAIDEN NAME <b>Harriet Southworth</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Doris H. Blake; same address as # 2.</b>		INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>433.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Ventricular fibrillation (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		DATE SIGNED <b>12-31-59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) 1/2/60	22b. DATE THEREOF 1/2/60	22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Crematory</b>	22d. LOCATION (City, town, or county) <b>Suitland Md.</b>	December 31, 1959					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Gandy Sons, Inc.</i>	ADDRESS <b>1756 Pa. Ave., N.W., Washington, D.C.</b>	24a. REC'D BY REGISTRAR DATE 4 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>						



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13988

Reg. Dist. No. 13988

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14028		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights									
f. STREET ADDRESS 7407 Gateway Blvd.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First ZENA Middle MARY Last BORZI		4. DATE OF DEATH Month December Day 14th, Year 1959									
5. SEX Female White		6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 14th, 1893		9. AGE (in years from birthday) 66 yrs.		IF UNDER 1YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailoress		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Joseph Sambataro		14. MOTHER'S MAIDEN NAME Unknown									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Carmelo E. Borzi, 2420 Iverson St., Wash. 21, D.C.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), sloing the underlying cause lost.		Acute pulmonary edema									
(b) DUE TO Coronary thrombosis											
(c) DUE TO Cardiovascular renal disease											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>James I. Boyd</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 12/14/1959			
EXAMINER'S NAME (Type) James I. Boyd, M.D.		22b. DATE THEREOF Burial Dec. 17, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Pr. Geo. Co., Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		ADDRESS Co., Riverdale, Md.		24a. REC'D BY REGISTRAR DATE DEC 17 '59		24b. REGISTRAR'S SIGNATURE <i>Orchard S. Kraus</i>					

**MECHANICAL EXAMINER'S CERTIFICATE OF DEATH**

11

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13989

14009

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville Md.</b>		c. LENGTH OF STAY IN lb <b>40 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4111 Gallatin St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marvette</b>	First <b>Vanessa</b>	Middle <b>Boswell</b>	Last 4. DATE OF DEATH <b>Dec 16, 1959</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 16, 1889</b>
9. AGE (In years lost birthday) <b>70 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	12. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>
13. FATHER'S NAME <b>John James Bowler</b>	14. MOTHER'S MAIDEN NAME <b>Mary J. Loriner</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>no</b>	INFORMANT <b>Harry A. Boswell</b>	Address <b>Hyattsville, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lupus Erythematosis</b> DUE TO <b>705.4</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1 - 9</b> , 19 <b>59</b> , to <b>12 - 16</b> , 19 <b>59</b> that I last saw the deceased alive on <b>12 - 16</b> , 19 <b>59</b> , and that death occurred at <b>6:40 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Waldo B. Moyers</b>		ADDRESS (Street, city or town, state) <b>M.D. 3503 Perry St</b>	
PHYSICIAN'S NAME (Type) <b>Waldo B. Moyers</b>		DATE SIGNED <b>12-17-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec 19, 1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Ft Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>	ADDRESS <b>Hyattsville Md.</b>	24a. REC'D BY REGISTRAR <b>DEC 23 '59</b>	24b. REGISTRAR'S SIGNATURE <b>John S. Haas</b>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retold by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

200-1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14029

## CERTIFICATE OF DEATH

Reg. Dist. No.

13990

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Prince Georges Co. MARYLAND		Maryland b. COUNTY Baltimore Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN lb 11/22/59. less 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) Laurel Sanitarium		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
3. NAME OF DECEASED (Type or print)		f. STREET ADDRESS 248 Rogers Forge Road	
First Irma		Middle D.	Last Burton
4. DATE OF DEATH Dec. 9 1959		Month	Day
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 21-1885	
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore-Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel C. Appleby		14. MOTHER'S MAIDEN NAME Clara T. Irving	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT S. Dixon Burton - (Son) 1217 Southdown Rd. Hillsborough - California		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - Cerebral DUE TO (c) Cerebral hemorrhages INTERVAL BETWEEN ONSET AND DEATH one week Many years One year	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 10, 1959, to Dec. 9, 1959, that I last saw the deceased alive on Dec. 8, 1959, and that death occurred at 5:15 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Jesse C. Coggins PHYSICIAN'S NAME (Type) Jesse C. Coggins M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/59	
22c. NAME OF CEMETERY OR CREMATORIAL Western Cem.		22d. LOCATION (City, town, or county) Balto., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Liebowitz		ADDRESS Baltimore	
24a. REC'D. BY REGISTRAR DATE DEC 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01 JOURNAL OF CLIMATE VOL. 20, 2007

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14030

## CERTIFICATE OF DEATH

Reg. Dist. No.

13991

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN 1b <b>3 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burtonsville</b>		d. STREET ADDRESS <b>14520 Columbia Road</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Laurel General Hospital, Inc.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>DEAVER</b>		First	Middle	Losl	4. DATE OF DEATH <b>CARR</b>	Month	Day	Year
5. SEX <b>male</b>	6. COLOR OR RACE <b>caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 11 1900</b>	9. AGE (In years lost birthday) <b>59 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Funeral construction - Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Alexander B. Carr</b>		14. MOTHER'S MAIDEN NAME <b>Marie A. Carr</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-6-2977</b>		17. INFORMANT <b>Mrs. Deanne Carr Burtonsville, Md</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, posterior, acute</b> DUE TO 260X						INTERVAL BETWEEN ONSET AND DEATH 1 day		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) <b>Arteriosclerotic Heart Disease</b>				1 day		
DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		(c) <b>Diabetes mellitus, with acute diabetic acidosis, without coma</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No injury</b>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>3 PM 10 Dec. 1959</b> , to <b>5:45 PM 10 Dec. 1959</b> that I last saw the deceased alive on <b>10 December 1959</b> , and that death occurred at <b>5:45 PM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>612 Main Street, Laurel, Maryland</b>		DATE SIGNED <b>10 Dec 59</b>		
ACTUAL SIGNATURE <b>Richard Compton, M.D.</b>								
PHYSICIAN'S NAME (Type) <b>J. Richard Compton, MD</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/14/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Burtonsville, Md</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>McKitt Donaldson, Laurel Md</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 17 '59		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13992

14010

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WASH. DISTRICT OF COLUMBIA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR 4922 LASALLE RD</b>		d. STREET ADDRESS <b>4365 - 13th Street N.E.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
				47X-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>MARYTHA</b>		First <b>M</b>	Middle <b>VIRGINIA</b>	Last <b>CARR</b>	4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>15</b> Year <b>1959</b>
S. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>JULY 26 1883</b>	9. AGE (In years lost birthday) <b>76 yrs.</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>20</b> Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WASH. DC</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>					
13. FATHER'S NAME <b>JAMES SPENCER JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>MARY ANNE POORE</b>		Address <b>Sister Agnes Patricia 4922 LaSalle Rd.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		INFORMANT	
				INTERVAL BETWEEN ONSET AND DEATH <b>25 hours</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332x</b> DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO					
(c) <b>Cerebral Thrombosis</b>					
<b>Cerebral arteriosclerosis</b>					
<b>Arteriosclerosis, general</b>					
<b>Osteoarthritis, spine, hips, knees</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>April 10, 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 14, 1959</b> , to <b>Dec 15, 1959</b> , that I last saw the deceased alive on <b>Dec 14, 1959</b> , and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>John F. Brennan Jr. M.D. 1034 PERRY ST. N.E. WASH. 17, D.C.</b>	
ACTUAL SIGNATURE <b>John F. Brennan Jr.</b>		DATE SIGNED <b>12/15/59</b>			
PHYSICIAN'S NAME (Type) <b>JOHN F. BRENNAN JR. M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Dec 18, 1959</b>		22b. DATE THEREOF <b>Dec 18, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Mary's</b>	
22d. LOCATION (City, town, or county) <b>Washington, D.C.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. J. Saffell, 475 21st St. N.W.</b>		ADDRESS <b>Washington, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>John F. Brennan Jr.</b>	

CHARTERED COMPANY

1000

RECEIVED IN EXERCISE OF POLICE  
SIXTY FIVE DOLLARS

30 last Oct 2018 on account of  
CHARTERED COMPANY

1000 RECEIVED HIRING FEE

OF 2018 FOR THE USE OF THE  
CHARTERED COMPANY

1000 RECEIVED HIRING FEE

FOR THE USE OF THE CHARTERED COMPANY

RECEIVED HIRING FEE

1000

1 Item 20b Film 250 5-7-60 a.m.s MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13993

Reg. Dist. No.

14031  
1. PLACE OF DEATH  
a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Riverdale

c. LENGTH OF STAY IN lb

2½ Hrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Pr. Geo.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

41 Laurel

d. STREET ADDRESS

352 Main Street

e. IS RESIDENCE  
ON A FARM?  
YES  NO

076

3. NAME OF  
DECEASED  
(Type or print)

First  
Michael

Middle

Chung

Last

4. DATE  
OF  
DEATH

December

15

19 59

5. SEX

Male

6. COLOR OR RACE

white

7. MARRIED  NEVER MARRIED

8. DATE OF BIRTH

9-8-53

9. AGE (in years  
last birthday)

6

yrs.

10. IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Schoolboy

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New York City

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Cooey Yee Chung

14. MOTHER'S MAIDEN NAME

Theadora Shiff

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)  
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Cooey Yee Chung; same address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Hemorrhage and shock

INTERVAL BETWEEN  
ONSET AND DEATH

812X

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b) Trauma, multiple and severe

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

returning home from school

Struck by a truck while playing in the street in Laurel, Md.

20c. TIME OF INJURY Month, Day, Year

Hour 2 p.m.  
2.45  
p.m. 12-15-59 19

20d. INJURY OCCURRED

While Not while  
of work  of work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

Highway

20f. (City or town)

Laurel

(County)

Pr. Geo. Sts.

(State)

Pr. Geo. Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

John T. Maloney, M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

December 15, 1959

22o. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

12/18/59

22c. NAME OF CEMETERY OR CREMATORIUM

Arlington Nat'l Cem

22d. LOCATION (City, town, or county)

Arlington, Va

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Se Witt Canadian Laurel, Md.

ADDRESS

24a. REC'D BY REGISTRAR

DATE DEC 21 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Trahan

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

V.S. A15ME(5)  
5M 9/55

**PHYSICAL EXAMINATION & CERUMENOL OF EARS**

TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12, 13. See: Birth Cert. et

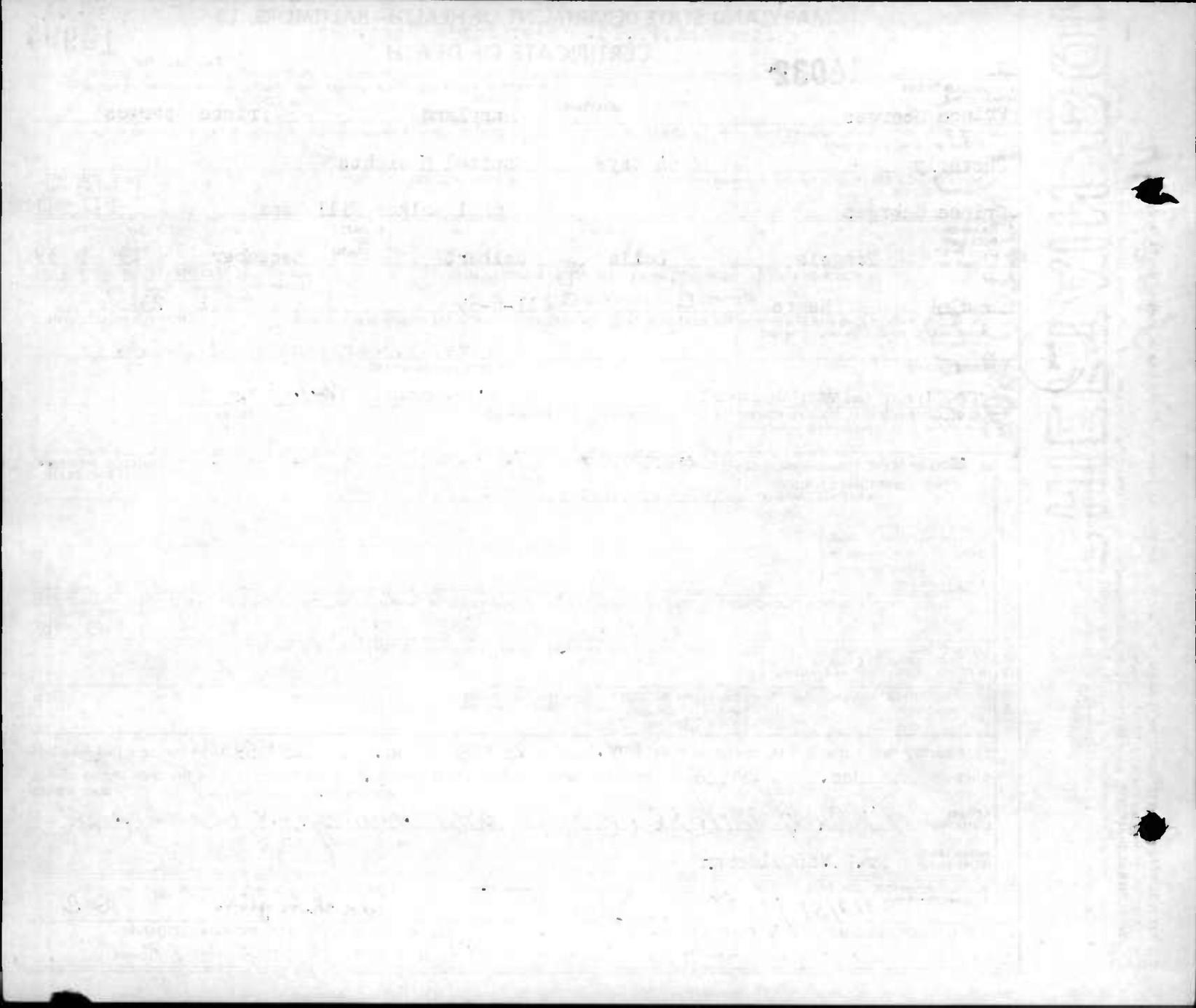
## CERTIFICATE OF DEATH

Reg. Dist. No.

13994

14032

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>54 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Capitol Heights</b>		d. STREET ADDRESS <b>6401 Walker Mill Road</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Tangela Della Colbert</b>		First	Middle	Last	4. DATE OF DEATH <b>December 29 1959</b>	Month	Day	Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-6-59</b>	9. AGE (In years last birthday) yrs. <b>1 23</b>	IF UNDER 1 YEAR Months <b>1</b>	IF UNDER 24 HRS. Days <b>23</b>	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cheverly, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Sterling Alvin Colbert</b>		14. MOTHER'S MAIDEN NAME <b>Theresa Proctor</b>				Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		INFORMANT				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cleft palate</b>								
INTERVAL BETWEEN ONSET AND DEATH								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>Cleft palate</b>		20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 25 1959</b> , to <b>Dec. 29 1959</b> , that I last saw the deceased alive on <b>Dec. 29 1959</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>3001 Cheverly Ave, Cheverly, Maryland</b>		DATE SIGNED <b>1/1/60</b>
ACTUAL SIGNATURE <b>B. Van Gelderan</b>		PHYSICIAN'S NAME (Type) <b>Dr. B. Van Gelderan</b>		M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>12/31/1959</b>		22b. DATE THEREOF <b>12/31/1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet</b>		22d. LOCATION (City, town, or county) <b>Washington</b>		(State) <b>D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert of Mason Funeral Home</b>		Q.E.T. THOMAS ADDRESS <b>1500 Nichols Ave</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		



**TO HOSPITAL** or **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14033 CERTIFICATE OF DEATH

Reg. Dist. No.

13995

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly,</b>		c. LENGTH OF STAY IN 1b <b>9 Hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		33 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
3. NAME OF DECEASED (Type or print) <b>Baby</b>		First	Middle
		Last	
4. DATE OF DEATH <b>Compton</b>		Month	Day
		Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11:10 AM</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Charles Compton</b>		14. MOTHER'S MAIDEN NAME <b>Patricia Imogene Cantwell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	INFORMANT <b>Mother</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Prematurity</b>		INTERVAL BETWEEN ONSET AND DEATH	
751X Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO <b>Meningocele</b> (c)		Congenital	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? <b>Y</b> <input checked="" type="checkbox"/> <b>N</b> <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-20</b> , 19 <b>59</b> , to <b>12-20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-20</b> , 19 <b>59</b> , and that death occurred at <b>8:20 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>M.D. 2513 Brookledge Rd.</b>	
ACTUAL SIGNATURE <b>R. D. Baker, M.D.</b>		DATE SIGNED <b>12-21-59</b>	
PHYSICIAN'S NAME (Type) <b>R. D. Baker, M.D.</b>			
22o. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>12/21/59</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Prince George's General Hospital</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b>		ADDRESS <b>Administrator</b>	22d. LOCATION (City, town, or county) (State) <b>Cheverly, Md.</b>
		24a. REC'D BY REGISTRAR DATE <b>DEC 30 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14035 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13997

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Georges General Hospital DOA</b>		c. LENGTH OF STAY IN lb d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rogers Heights</b>		e. STREET ADDRESS <b>5304 Gallatin Street</b>	
3. NAME OF DECEASED (Type or print) <b>Frances Gaines Davis</b>		4. DATE OF DEATH <b>December 25, 1959</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-24-58</b>
9. AGE (in years last birthday) <b>61 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Henry Stone</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Canning</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Marguerite Davis; same address</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) <b>Cardiovascular renal disease</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John T. Maloney</i>	DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 25, 1959		
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-28-59</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Ft Lincoln</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home - Washington D.C.</b>		24a. REC'D BY REGISTRAR DATE DEC 29 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14035

## CERTIFICATE OF DEATH

Reg. Dist. No.

13998

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>14 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Washington 22</b>		d. STREET ADDRESS <b>6852 Allentown Rd.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Walter</b>	Middle <b>B.</b>	Last <b>Defibaugh</b>	4. DATE OF DEATH <b>Dec. 16 1959</b>	Month <b>Dec.</b>	Day <b>16</b>	Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 June 1959</b>	9. AGE (In years last birthday) yrs. <b>5</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Dots Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Walter Defibaugh</b>				14. MOTHER'S MAIDEN NAME <b>Delores Ann Ballenger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <b>Hospital</b>		Address <b>Cheverly Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b> DUE TO <b>Acute bronchopneumonia with abscess formation, bilateral.</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Part II</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Saxton</b>	(County) <b>Pennsylvania</b> (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Arthur W. Ballenger, M.D.</b>				ADDRESS (Street, city or town, state) <b>3001 Cheverly Ave., Cheverly, Md.</b>			
PHYSICIAN'S NAME (Type)		DATE SIGNED <b>1959</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 18, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Rhoates Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Saxton Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Mann</b>	

TO HOSPITAL may be retained by the hospital or attending physician and completely filled in by the medical director.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PHOTO NO 31A 201102

2011

exhibited by  
John C. Weller  
1971-80

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14036

## CERTIFICATE OF DEATH

Reg. Dist. No.

13993

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Seat Pleasant (Washington 27 P.O.)</b>		d. STREET ADDRESS <b>6201 Rollins Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>C</b>	Last <b>Donn</b>	4. DATE OF DEATH <b>Dec 17</b>	Month <b>19 59</b>	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 4, 1881</b>	9. AGE (In years last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months <b>6201 Rollins Ave.</b>	IF UNDER 24 HRS. Months <b>U.S.A.</b>	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Painting</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mart Donn</b>				14. MOTHER'S MAIDEN NAME <b>Mary Grisby</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Thelma N. Heffner</b>		6201 Rollins Ave. Seat Pleasant, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral Vascular accident</b> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-Vascular disease</b> DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>NOV - 15, 1959</b> , to <b>Dec. 17</b> , 1959, that I last saw the deceased alive on <b>12-17</b> , 19 59, and that death occurred at <b>9:30A M</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>7016 Greig St.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Max M. Herzberg</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. Max. Herzberg, M.D.</b> Seat Pleasant, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/19/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers co 517 11<sup>th</sup> St. SE</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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Intergovernmental cooperation

is a major factor in the success of the program

in the U.S.

Local governments are involved in the planning process

and implementation

of the program

Local government

is the primary source of funding for the program

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
Items 8 & 9, Film G-254 12/31/59.cac.  
**CERTIFICATE OF DEATH**

Reg. Dist. No. 14000

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	c. LENGTH OF STAY IN 1b <i>8 mos 4 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>District Heights</i>	d. COUNTY <i>Prince George's</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION <i>Mrs Bell's Nursing Home</i>	d. STREET ADDRESS <i>7215 Clarendon St</i>		
3. NAME OF DECEASED (Type or print) <i>Michael</i>	First <i>M</i>	Middle <i>T</i>	Last <i>Dress</i>
4. DATE OF DEATH <i>12/28/59</i>	Month <i>12</i>	Day <i>28</i>	Year <i>1959</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/25/1918</i>
9. AGE (In years last birthday) <i>1 yr.</i>	10. IF UNDER 1 YEAR <i>10 months</i>	11. IF UNDER 24 HRS. <i>4 days</i>	12. IF UNDER 24 HRS. <i>4 hours</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>infant</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>Washington DC</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John J Dress</i>	14. MOTHER'S MAIDEN NAME <i>Theresa Harlow</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>752 X 123 4567</i>	17. INFORMANT <i>Theresa Dress</i>	Address <i>Same as X-2</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hydrocephalus (internal)</i> DUE TO <i>752 X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>last on</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4/25/59</i> , to <i>12/28/59</i> , that I last saw the deceased alive on <i>12/28/59</i> , 1959, and that death occurred at <i>4:10 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thomas A. Christensen</i>	ADDRESS (Street, city or town, state) <i>6905 Bally St. L</i>		DATE SIGNED <i>12/28/59</i>
PHYSICIAN'S NAME (Type) <i>Thomas A. Christensen</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-30-59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Holy Cross</i>	22d. LOCATION (City, town, or county) <i>Wash. D.C.</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>K. G. Mattingly</i>	ADDRESS <i>131-117th St. S.E.</i>	24a. REC'D BY REGISTRAR DATE <i>DEC 30 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>

STATE OF GEORGIA - DEPARTMENT OF HEGELIAN - CERTIFICATE OF DESIGN

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14037

## CERTIFICATE OF DEATH

Reg. Dist. No.

14901

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>1213-61st St NW</i>		b. COUNTY <i>DC</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. LENGTH OF STAY IN 1b <i>9 days (Hosp.)</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Washington 27, D.C.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>EUGENE LELAND MEMORIAL Hosp.</i>		d. STREET ADDRESS <i>1213-61st Place S.E.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>EMMA</i>	Middle <i>G.</i>	Last <i>Dunwoody</i>	4. DATE OF DEATH <i>12 18 1959</i>	Month <i>12</i>	Day <i>18</i>	Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Mar. 6 1889</i>	9. AGE (In years lost birthday) <i>70 yrs.</i>	IF UNDER 1 YEAR <i>Months</i>	IF UNDER 24 HRS. <i>Days</i>	Hours <i>Hours</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hauswife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Fleet</i>		14. MOTHER'S MAIDEN NAME <i>Ruby Garnett</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Hospital records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>584X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. { (b) DUE TO (c) Cholelithitis + Obstruction of Sphincter of Oddi: 10 days							
INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Acute Parotitis on Rt</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>					
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State) <i>—</i>	
21. I certify that I attended the deceased from <i>Nov. 15, 1959</i> , to <i>DEC. 18, 1959</i> , that I last saw the deceased alive on <i>Dec. 18, 1959</i> , and that death occurred at <i>11:30 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Rowland Wilkinson</i>		M.D.		ADDRESS (Street, city or town, state) <i>4404 Gwynnsbury Road</i>		DATE SIGNED <i>12-19-59</i>	
PHYSICIAN'S NAME (Type) <i>Rowland E. Wilkinson</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 21-59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Brunington Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Brunington Va</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Demmons Bros 1661-9d Hope Rd &amp; Z.</i>		ADDRESS <i>most do</i>		24a. REC'D BY REGISTRAR <i>DEC 22 1959</i>		24b. REGISTRAR'S SIGNATURE <i>C. H. &amp; K.</i>	

81 ЗВОНИЛ ВІД ПІДПІЛЯЩИХ САКЧАРСЬКИХ

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14002

14038

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		X		M		077		I		2		B					
1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>		3. NAME OF DECEASED (Type or print) <b>George</b>		First <b>Paul</b>		Middle <b>Sr. Duvall</b>		4. DATE OF DEATH <b>Dec 18</b>		Month Year <b>19 59</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>2 Hr</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colmar Manor</b>		d. STREET ADDRESS <b>3833 Bladensburg Rd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>																	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 11, 1892</b>		9. AGE (In years last birthday) <b>67 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bar Tender</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John W Duvall</b>										14. MOTHER'S MAIDEN NAME <b>Lillian Wilson</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		(If yes, give war or dates of service) <b>W W I</b>		16. SOCIAL SECURITY NO. <b>213 16 244A</b>		INFORMANT <b>Ann L Duvall</b>		Address <b>Colmar Manor, Md.</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b>		DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, lost. <b>Bronchopneumonia</b>		(b)  DUE TO <b>Diabetes mellitus. Generalized arteriosclerosis</b>		(c)								INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus. Generalized arteriosclerosis</b>														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Injury occurred while at work</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>College City, Md.</b>		(County) <b>Wheaton</b>		(State) <b>Md.</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>Dec. 18 1959</b>																	
21. I certify that I attended the deceased from <b>12-13</b> , 19 <b>59</b> , to <b>Dec. 18</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Dec. 18</b> , 19 <b>59</b> , and that death occurred at <b>1:30 PM</b> from the causes and on the date stated above.																	
ACTUAL SIGNATURE <b>George Hageage</b>		PHYSICIAN'S NAME (Type) <b>Dr. Geo. Hageage, M.D.</b>		ADDRESS <b>3717-38th Line</b>		ADDRESS (Street, city or town, state) <b>College City, Md.</b>		DATE SIGNED <b>12-18-59</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/22/59</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven Cemetery</b>		22d. LOCATION (City, town, or county) <b>Wheaton</b>		(State) <b>Md.</b>									
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>											



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14039

## CERTIFICATE OF DEATH

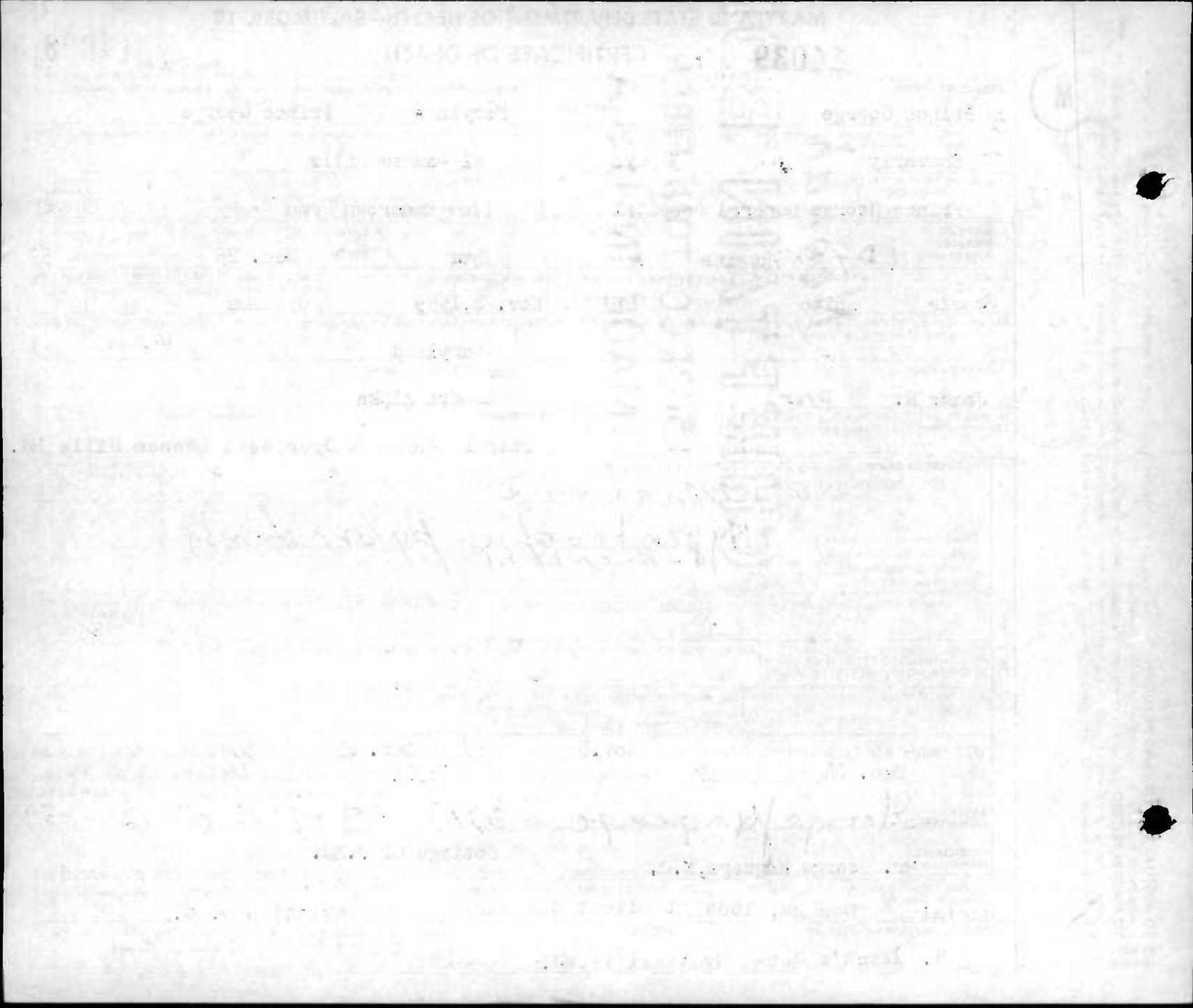
Reg. Dist. No.

14003

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>W. Lanham Hills</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. STREET ADDRESS <b>7726 Emerson Road</b>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Dyer</b>	Middle <b>R</b>	Last <b>Dyer</b>	4. DATE OF DEATH	Month <b>Dec. 25</b>	Day <b>m 19</b>	Year <b>59</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 8, 1959</b>	9. AGE (In years last birthday) <b>6 Weeks</b>	IF UNDER 1 YEAR Months <b>6</b>	IF UNDER 24 HRS. Days <b>Weeks</b>	Hours <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>James R. Dyer</b>				14. MOTHER'S MAIDEN NAME <b>Sandra Ripka</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>no --</b>		INFORMANT <b>Father James R Dyer</b>		Address <b>West Lanham Hills Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malaria</b>							
756.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Hyper trophy pyloro stenosis</b>							
DUE TO (c) <b>Congenital</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 8</b> , 1959, to <b>Dec. 25</b> , 1959, that I last saw the deceased alive on <b>Dec. 24</b> , 1959, and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Cottage City Md.</b>							
DATE SIGNED <b>12-59</b>							
ACTUAL SIGNATURE <b>George Hageage</b>							
M.D. <b>3717-3841</b>							
PHYSICIAN'S NAME (Type) <b>Dr. George Hageage, M.D.</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 28, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt Olivet Cemetery</b>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>F. Gasch's Sons Hyattsville Md.</b>							
24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>							
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **14004**

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>1 Month</b>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First <b>James</b>	Middle <b>Frederick</b>	Last <b>Dyson</b>	4. DATE OF DEATH <b>Dec. 1</b>	Month Year <b>59</b>						
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-4-86</b>	9. AGE (In years last birthday) <b>73 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>	Days <b>0</b>	Year <b>59</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Postal Employee</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Md</b>					
13. FATHER'S NAME <b>William W Dyson</b>			14. MOTHER'S MAIDEN NAME <b>Katherine Moran</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>none</b>			INFORMANT <b>Vivian Huntley Cheverly, Md.</b>					
Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b>											
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>610X</b>											
(b) <b>Uremia &amp; Renal Insufficiency 11/59</b>											
DUE TO (c) <b>Chronic Benign Prostatic Hypertrophy 1955</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Cholecystectomy: Pancreactomy for CA in 1949</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Hour o. m. <b>10</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) <b>Riverdale</b>	(County) <b>Rd</b>	(State) <b>Md</b>
21. I certify that I attended the deceased from <b>11/13</b> , 19 <b>9</b> , to <b>12/1</b> , 19 <b>9</b> , that I last saw the deceased alive on <b>11/30</b> , 19 <b>9</b> , and that death occurred at <b>10:45 AM</b> , from the causes and on the date stated above.									ADDRESS (Street, city or town, state) <b>6300 Riverdale Rd</b>		
ACTUAL SIGNATURE <b>William A. Stecher</b>									DATE SIGNED		
PHYSICIAN'S NAME (Type) <b>WILLIAM A. STECHER</b>									<b>RIVERDALE, MARYLAND</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 4, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>			22d. LOCATION (City, town, or county) <b>Colmar Manor, Md.</b>		(State) <b>Md</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>F GASCH Sons</b>									ADDRESS <b>HYATTSVILLE Md</b>		
24a. REC'D BY REGISTRAR <b>DEC 4 '59</b>									24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trahan</b>		



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14005

Reg. Dist. No.

14012

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>XXXXXX</b> b. COUNTY <b>XXXXXX</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>		c. LENGTH OF STAY IN 1b <b>Jan 11/59</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PAINT BRANCH NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

090

3. NAME OF DECEASED (Type or print)	First <b>SAMUEL</b>	Middle <b>R.</b>	Last <b>EDMONDS</b>	4. DATE OF DEATH <b>12 - 18</b>	Month <b>Dec</b>	Day <b>19</b>	Year <b>59</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 21, 1880</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROPRIETOR CINDER BLOCK BUSINESS</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>CHEVERLY AVENUE</b>	11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13. FATHER'S NAME <b>JOHN ROBERT EDMONDS</b>	14. MOTHER'S MAIDEN NAME <b>ANNIE BROWN</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>579-03-3976</b>	17. INFORMANT <b>HAZEL B. LA MAR</b>	3200 <del>Cheverly</del> Avenue Cheverly, Maryland
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>b</b>	<b>Cardiovascular renal disease</b>
DUE TO <b>c</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>COIMAR</b>	(County) <b>MANOR</b>	(State) <b>MARYLAND</b>
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .
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ACTUAL SIGNATURE <i>John J. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <b>12-19-59</b>
EXAMINER'S NAME (Type) <b>John J. Maloney, MD</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	EDEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12/21/1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>FORT LINCOLN CEMETERY</b>	22d. LOCATION (City, town, or county) <b>COIMAR MANOR MARYLAND</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home</b>	ADDRESS <b>Mt. Rainier Md</b>	24a. REC'D BY REGISTRAR <b>DEC 22 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Pages 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14017 CERTIFICATE OF DEATH

Reg. Dist. No.

14006

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY PR. GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT RAINIER	c. LENGTH OF STAY IN lb 34RS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 MT RAINIER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS 1 3405 NEWTON ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First ALBERT	Middle ERNEST	Last EDWARDS
4. DATE OF DEATH	Month DEC	Day 8	Year 1959
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 22, 1881
9. AGE (In years lost 78 yrs.)		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY STEEL MILL	
10c. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ABRAHAM EDWARDS		14. MOTHER'S MAIDEN NAME POLLY MINTEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 271-03-7569 17. INFORMANT CHANCEY EDWARDS Address LAUREL, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO GENERALIZED CARCINOMATOSIS INTERVAL BETWEEN ONSET AND DEATH 1 MONTH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO CARCINOMA OF COLON (c)		1 MONTH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV 1, 1959, to DEC 8, 1959, that I last saw the deceased alive on DEC 8, 1959, and that death occurred at 11:30 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Samuel J. N. Sugar M.D. ADDRESS (Street, city, or town, state) 4300 Kaywood DRIVE DATE SIGNED Dec 8, 1959 PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR MT RAINIER, Md.			
22a. BURIAL, CREMATION, REINTERMENT, ETC. BURIAL 12-12-1959		22b. DATE THEREOF 12-12-1959	
22c. NAME OF CEMETERY, OR CREMATORIAL Grand-Vieux		22d. LOCATION (City, town, or county) STRASBURG, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Mattingly		24a. REC'D BY REGISTRAR ADDRESS 131-11-8888 DATE DEC 11 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Straus			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

## CERTIFICATE OF DEATH

18012

Date of Birth

Name of deceased person

Relationship

Place of death

Sex	Male	Date of birth	1910-01-01	Age at death	80 years
Color	White	Marital status	Married	Occupation	Retired
Height	5' 6"	Weight	130 lbs	Residence	1000 E. 36th St.
Cause of death					
Diseases or conditions existing prior to death					
Other information concerning death					

Method of death	Heart Disease	Age at death	80 years	Time of death	10:00 AM
Time of death	10:00 AM	Place of death	Hospital	Time of report	10:00 AM
Time of report	10:00 AM	Reported by	Physician	Date of report	10/20/00
Method of death	Heart Disease	Age at death	80 years	Time of death	10:00 AM
Time of death	10:00 AM	Place of death	Hospital	Time of report	10:00 AM
Time of report	10:00 AM	Reported by	Physician	Date of report	10/20/00

Method of death

Time of death

Place of death

Time of report

Reported by

Date of report

This certificate is issued under the authority of the State of Maryland, and is valid only if signed by a physician, dentist, or licensed practical nurse.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14102

## CERTIFICATE OF DEATH

Reg. Dist. No.

14007

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE	
<i>Prince Georges</i> <i>MARYLAND</i>		<i>Maryland</i> <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
<i>Bradbury Park.</i>	<i>3 yrs</i>	<i>Bradybury Park, Suitland</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS		
<i>4615 Brookfield Dr.</i>	<i>4615 Brookfield Dr.</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	<i>IDA</i>		<i>R. EDWARDS</i>
4. DATE OF DEATH	Month	Day	Year
	<i>Dec</i>	<i>26</i>	<i>1959</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH
<i>Female</i>	<i>Pauca</i>	<i>WIDOWED <input checked="" type="checkbox"/></i> DIVORCED <input type="checkbox"/>	<i>Sept 14, 1880</i>
8. AGE (In years last birthday)	9. IF UNDER 1 YEAR	10. IF UNDER 24 HRS.	
<i>79 yrs.</i>	Months <i>0</i>	Days <i>0</i>	
11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
<i>Washington, D.C.</i>	<i>U. S. A.</i>		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>William Bowman</i>	<i>Sallie Gilbert</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address <i>4615 Brookfield Dr.</i>
<i>No</i>	<i>None</i>	<i>Mrs Anna Tomlinson</i>	<i>Suitland, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular - renal disease</i> DUE TO <i>442X</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO <i>old left kidney</i> 1 years (c) <i>Hypertensive heart disease</i> DUE TO <i>old left kidney</i> 15 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Hour o. m. p. m.		While at work <input type="checkbox"/> of work <input type="checkbox"/>	20f. (City or town) (County) (State)
19			<i>Dec 26, 1959</i> (Baltimore) (Baltimore) (Md.)
21. I certify that I attended the deceased from <i>Jan 2, 1956</i> , to <i>Dec 26, 1959</i> , that I last saw the deceased alive on <i>12-26-1959</i> , and that death occurred at <i>4:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE	ADDRESS (Street, city or town, state)		
<i>David S. Gordon</i>	<i>5731 23rd Parkway SE 1226-59</i>		
PHYSICIAN'S NAME (Type)	DATE SIGNED		
<i>DAVID S. GORDON, M.D.</i>	<i>12-26-59</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>12-30-59</i>	<i>Arlington National</i>	<i>Arlington, Virginia</i>
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<i>W.W. Chambers Co Inc Washington, D.C.</i>		<i>DEC 29 '59</i>	<i>Arthur S. Lewis</i>

БІ-Э-ДІ-МІ-ЧІ-КІ-ЛІ-НІ-СІ-ЛІ-СІ-ЛІ-СІ-ЛІ-СІ-ЛІ-СІ-ЛІ

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14005

## CERTIFICATE OF DEATH

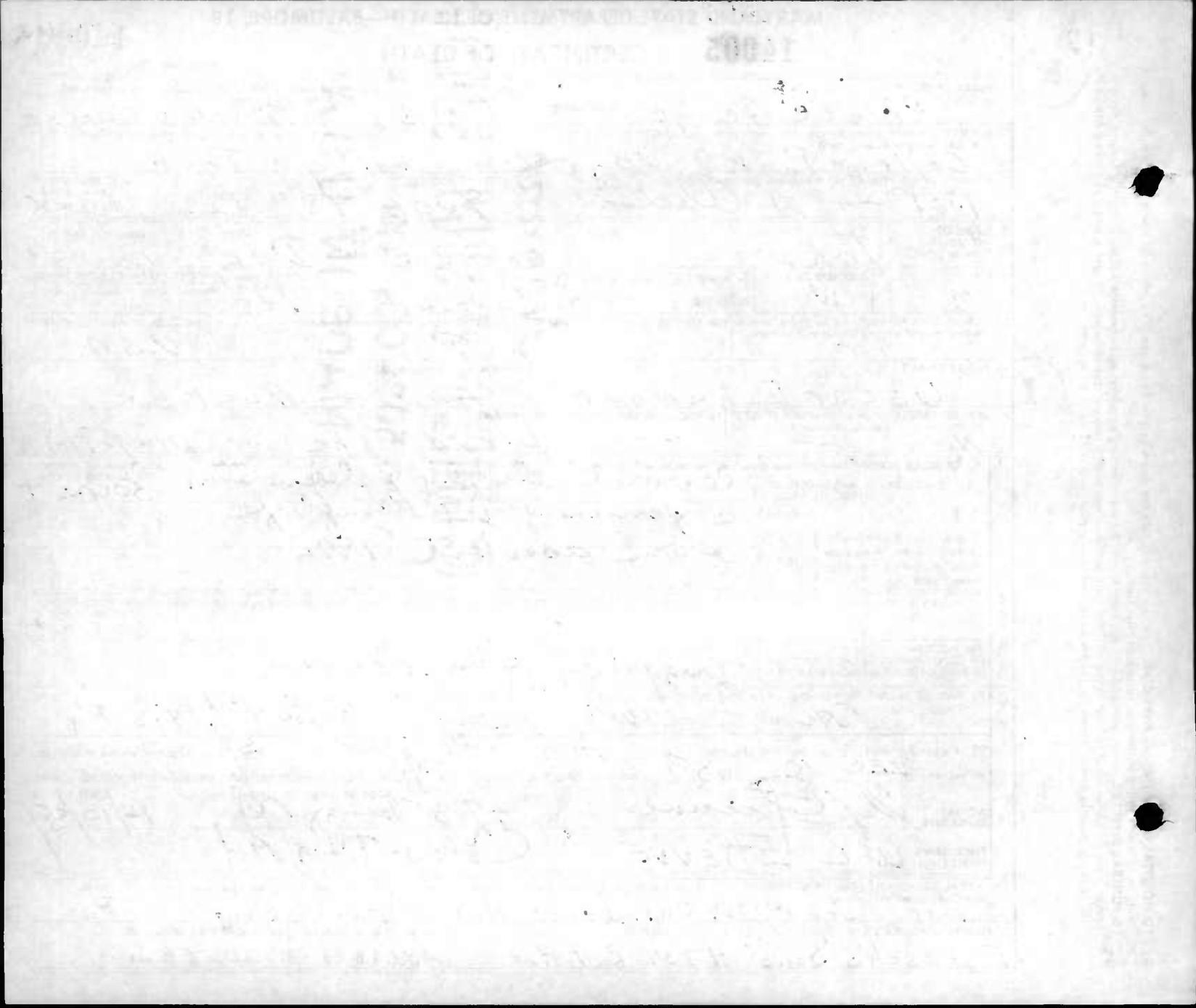
14008

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>	c. LENGTH OF STAY IN 1b <i>10 yr.</i>	b. COUNTY <i>Prince George</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>14 College Park</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9001 - 48th Place</i>	e. STREET ADDRESS <i>19001 48th Pl.</i>	d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John</i>	First <i>J</i>	Middle <i></i>	Last <i>Eshenour</i>
4. DATE OF DEATH <i>Dec 10</i>	Month <i>Dec</i>	Day <i>10</i>	Year <i>1959</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 10, 1885</i>
9. AGE (In years last birthday) <i>74 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>more</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Pa.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Oscar Eshenour</i>	14. MOTHER'S MAIDEN NAME <i>Annie Hocker</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i></i>	INFORMANT <i>Lloyd Eshenour, College Park Md.</i>	Address <i></i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>962X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Cerebral atrophy &amp; degeneration</i> (c) DUE TO <i>&amp; permanent left hemiplegia</i> from accident (1892)			
INTERVAL BETWEEN ONSET AND DEATH <i>50 yrs +</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Dragged by farm horse</i>	
20c. TIME OF INJURY Hour a. m. p. m. <i>Fog 19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Farm</i>	20f. (City or town) (County) (State) <i>Rutherford 1975 Pa.</i>
21. I certify that I attended the deceased from <i>Aug 1949</i> to <i>DEC 1959</i> that I last saw the deceased alive on <i>DEC 10 1959</i> , and that death occurred at <i>535</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W.L. Etienne</i>	ADDRESS (Street, city or town, state) <i>4713 College St., Md.</i>		DATE SIGNED <i>12/10/59</i>
PHYSICIAN'S NAME (Type) <i>W.L. Etienne</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec. 14, 1959</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Chambers Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Harrisburg Pa.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>	ADDRESS <i>4739-Balt. Ave.</i>	24a. REC'D BY REGISTRAR <i>DEC 16 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14000

## 14041 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>25 Riverdale</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Georges San Hosp</i>		d. STREET ADDRESS <i>16406 - 46th Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Robert Garfield Ferguson</i>		First	Middle
4. DATE OF DEATH <i>Dec 17 1959</i>		Lost	Month Day Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-25-81</i>
9. AGE (In years last birthday) <i>78 yrs.</i>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>US GOV'T Public Works Admin.</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Robert Ferguson</i>		14. MOTHER'S MOTHER'S NAME <i>Mary Beach</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Clinton Ferguson, same address</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
<i>Acute congestive heart failure</i>			
<i>Cardiovascular renal disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John J. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>12-17-59</i>
EXAMINER'S NAME (Type) <i>JOHN J. MALONEY, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/21/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Washington Natl. Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Col-2901</i>	ADDRESS <i>14th St. N.W. Washington, D.C.</i>	24a. REC'D BY REGISTRAR DATE DEC 21 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Tracy</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 4 and 2 with the registrar prior to burial, cremation, or removal.

WISCONSIN STATE DEPARTMENT OF HEALTH - TUBERCULOSIS  
COURT MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH	DEATH CERTIFIED
REASON FOR CERTIFICATION						
EXAMINER'S SIGNATURE						

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

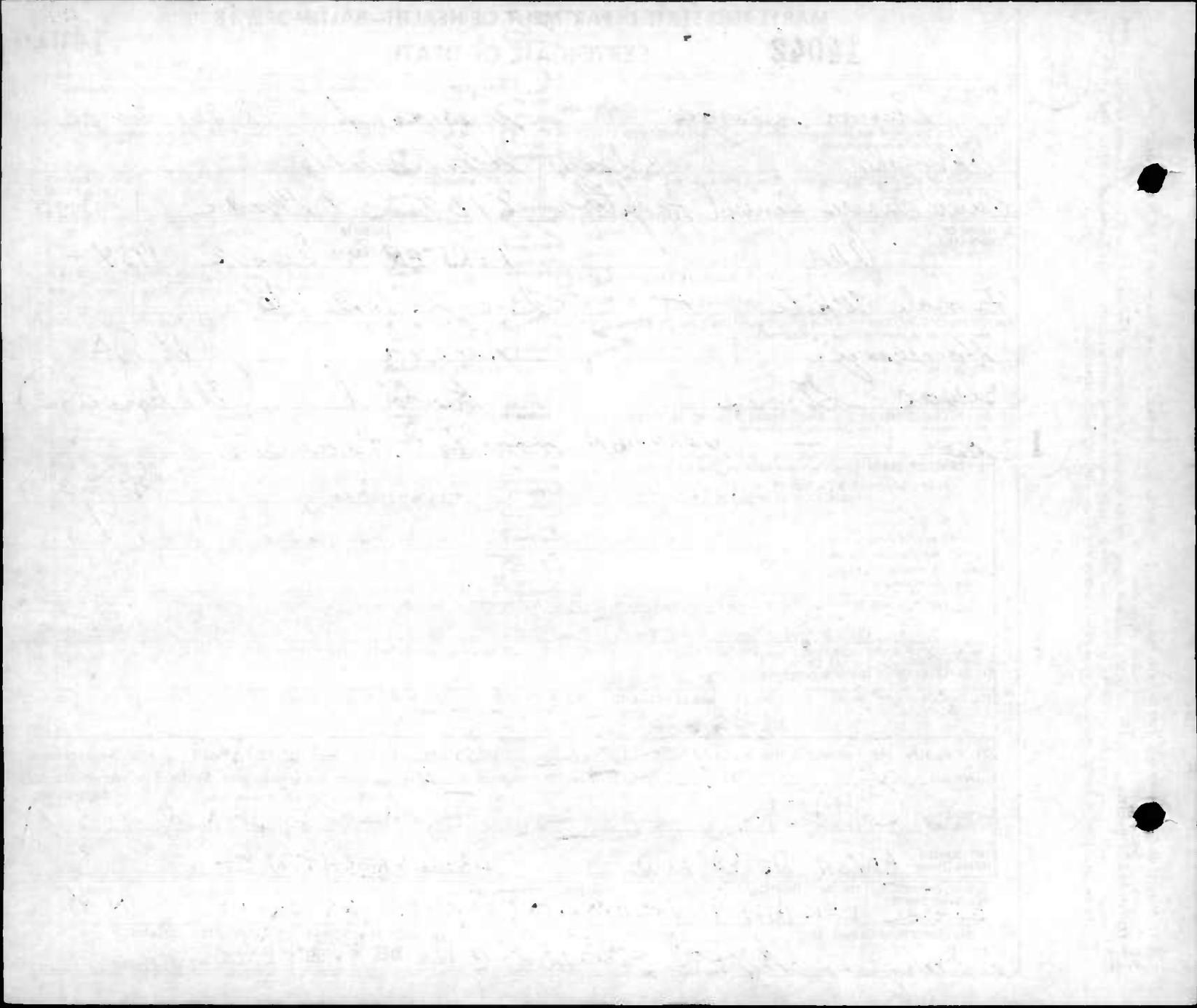
14042

## CERTIFICATE OF DEATH

Reg. Dist. No.

14010

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Prince Georges</i>		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Cheverly</i>		<i>Hughtsville 15</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Prince George General Hospital</i>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>JDA</i>			<i>FERSTER</i>
4. DATE OF DEATH	Month	Day	Year
<i>Dec 2 - 1959</i>			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<i>Female</i>	<i>White</i>	<i>Dec 26 1881</i>	<i>76 yrs.</i>
9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?
<i>76 yrs.</i>	<i>Housewife</i>	<i>-</i>	<i>USA</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
<i>Isaac Gross</i>	<i>Rachel</i>	<i>NO</i>	
16. SOCIAL SECURITY NO.	INFORMANT	17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
<i>UNKNOWN</i>	<i>Hospital Records</i>	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
DUE TO		<i>Acute Coronary Necrosis</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		<i>Arteriosclerotic Heart Disease</i>	
(b)		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
DUE TO		<i>5 yrs</i>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11-28</i> , 19 <i>59</i> , to <i>12-2</i> , 19 <i>59</i> that I last saw the deceased alive on <i>12-2</i> , 19 <i>59</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>DeBetz</i>		ADDRESS (Street, city or town, state) <i>Hughtsville 15</i>	
PHYSICIAN'S NAME (Type) <i>Aaron DeBetz M.D.</i>		DATE SIGNED <i>Dec 2 - 1959</i>	
22a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		22b. DATE THEREOF <i>DEC 4 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>WASHINGTON CEMETERY</i>		22d. LOCATION (City, town, or county) <i>BROOKLYN N.Y.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Dangovsky &amp; Sons Wash D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 4 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14011

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
Mt. Rainier		10 yrs		16 Mt. Rainier, Md.		14019-36 <sup>th</sup> street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		4019-36 St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Elizabeth Alice Fleming					Dec. 10, 1959			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
F		W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	21 Nov	74 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife own home				London England.		U.S.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
David Hockney		Margaret C. Hazel						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address		
(If yes, give war or dates of service)								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO Cancer large intestine INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO 4 months								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Hypertensive heart disease								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1953 to 10 Dec 1959, that I last saw the deceased alive on 1959, and that death occurred at 8a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Dr. James E. Mattingly, M.D. DATE SIGNED 22. LOCATION (City, town, or county) (State) PHYSICIAN'S NAME (Type) Thomas E. Mattingly, M.D. 10 Dec 59 Colmar Manor, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/59		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier, Md.		24a. REC'D BY REGISTRAR DEC 14 '59		24b. REGISTRAR'S SIGNATURE Orlan S. Trahan		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

31041

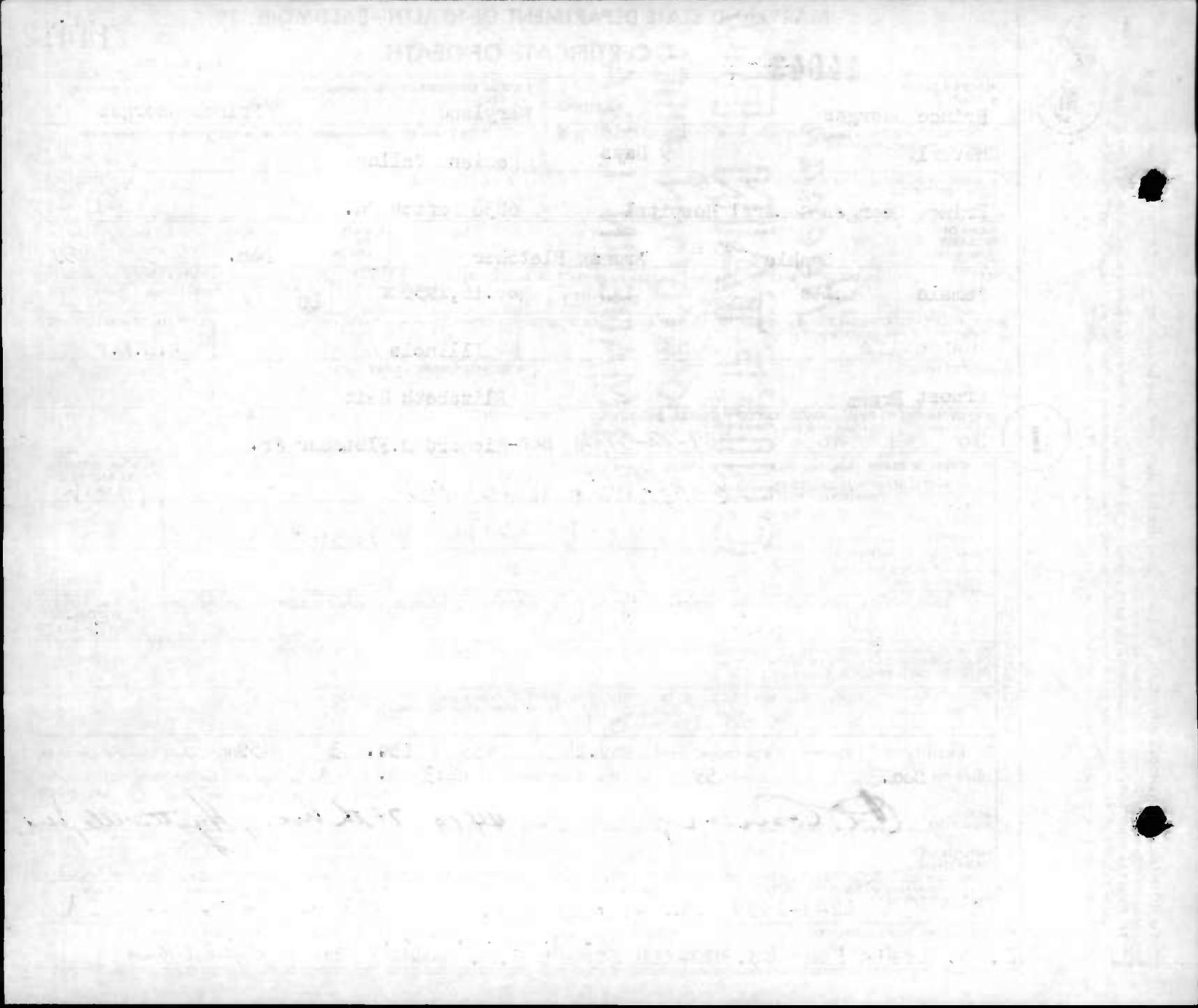
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

14012

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>9 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Radiant Valley</b>		d. STREET ADDRESS <b>6838 Barton Rd.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>m Sophia</b>	Middle <b>Branz</b>	Last <b>Ernest Fletcher</b>	4. DATE OF DEATH	Month <b>Dec.</b>	Doy <b>3</b>	Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Nov. 16, 1879</b>	8. AGE (In years last birthday) <b>80 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ernest Branz</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Reit</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>357-22-5724</b>	INFORMANT <b>Son-Richard D. Fletcher Jr.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332x</b> DUE TO <b>Encephalomalacia</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> (c) <b>Multiple gastric ulcers.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Multiple gastric ulcers.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 21</b> , 1959, to <b>Dec. 3</b> , 1959, that I last saw the deceased alive on <b>Dec. 3</b> , 1959, and that death occurred at <b>2:35 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>O. Connor</b>		ADDRESS (Street, city or town, state) <b>M.D. 4410 74th Ave., Hyattsville, Md.</b>					
PHYSICIAN'S NAME (Type)		DATE SIGNED					
22a. BURIAL, CREMATION <b>CREMATION</b>		22b. DATE THEREOF <b>12-5-1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Ft. Lincoln Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Colmor Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.Wm. Lee's Sons Co.</b>		ADDRESS <b>300-4th Street N.E.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14046

## CERTIFICATE OF DEATH

14013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		c. LENGTH OF STAY IN lb 8 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 38 F--Crescent Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARY	Middle FANNIE H.	Last FLORENCE
4. DATE OF DEATH	Month December	Day 29th,	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 5th, 1886
		DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Taneytown, Maryland
13. FATHER'S NAME Tobias Martin		14. MOTHER'S MAIDEN NAME Ida (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Paul R. Florence, 38 F--Crescent Rd., Greenbelt, Md. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 1hr	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO		GENERALIZED ANTERIOSCLEROSIS 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/2, 1958, to 12/29, 1959, that I last saw the deceased alive on 12/14, 1959, and that death occurred at 5:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Norman D. Comeau M.D. 3503 Perry Street, Mt. Rainier, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/2/1960	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.		24a. REC'D BY REGISTRAR DATE JAN 4 '60	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ВСЕМ ПРИЧАСТИТЬСЯ К СОБЫТИЮ—САЛЮДАМ

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 1 Film G254 1-4-60 et <b>CERTIFICATE OF DEATH</b>									
Reg. Dist. No. 14014									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <u>MARYLAND</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLB</u> b. COUNTY <u>Pr. GEORGE</u>				
<b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>		<b>c. LENGTH OF STAY IN lb</b>		<b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>College. Park</u>					
<b>d. NAME OF HOSPITAL</b> (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>					<b>d. STREET ADDRESS</b> <u>4618. Harvard. Rd</u>				
<b>3. NAME OF DECEASED</b> (Type or print) <u>Ruth</u>					First	Middle	Lost	4. DATE OF DEATH	Month
							<u>French</u>	12	Day
								25	Year
									1959
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4.1.1902</u>		<b>9. AGE (In years lost birthday)</b> <u>57 yrs.</u>	
								IF UNDER 1 YEAR	IF UNDER 24 HRS.
								Months	Days
								Hours	Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Librarian</u>					<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Govt.</u>				
					<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>				
<b>13. FATHER'S NAME</b> <u>John. C. French</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Jennie. E. Beck</u>				
					<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> <small>(Yes, no, or unknown)</small> <u>No</u>				
					<b>16. SOCIAL SECURITY NO.</b> <small>If yes, give war or dates of service</small> <u>Mildred. Wagner. 4618. Harvard. Rd. College</u>				
					<b>INFORMANT</b> <u>Mildred. Wagner. 4618. Harvard. Rd. College</u>				
					<b>Address</b> <u>12. CITIZEN OF WHAT COUNTRY?</u> <u>U.S.A.</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]									
<b>PART I. DEATH WAS CAUSED BY:</b> <small>IMMEDIATE CAUSE (a)</small> <u>170X</u> <b>Metastatic carcinoma of</b> <small>DUE TO</small> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</small> <u>(b)</u> <b>leg breast</b> <small>DUE TO</small> <u>(c)</u>									
<small>INTERVAL BETWEEN ONSET AND DEATH</small> <u>3 yrs.</u>									
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)</b>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)									
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 1b.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year <small>Hour o. m.</small> <small>p. m.</small> <u>19</u>									
<b>20d. INJURY OCCURRED</b> <small>While at work</small> <input type="checkbox"/> <small>Not while at work</small> <input type="checkbox"/>									
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <small>(City or town)</small> <u>20f.</u> <small>(County)</small> <u>20f.</u> <small>(State)</small>									
<b>21. I certify that I attended the deceased from</b> <u>MAY</u> , 1959, <b>to</b> <u>Dec. 25, 1959</u> <b>that I last saw the deceased alive on</b> <u>Dec 25, 1959</u> , <b>and that death occurred at</b> <u>11:20 P.M.</u> , from the causes and on the date stated above. <small>ADDRESS (Street, city or town, state)</small> <u>G. Leonard Gold</u> <small>M.D.</small> <u>8641 Colesville Road</u> <small>DATE SIGNED</small> <u>Silver Spring, Md.</u>									
<b>ACTUAL SIGNATURE</b> <u>G. Leonard Gold</u> <small>M.D.</small> <u>8641 Colesville Road</u> <small>Silver Spring, Md.</small>									
<b>PHYSICIAN'S NAME (Type)</b>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation</u>		<b>22b. DATE THEREOF</b> <u>12.28.59</u>		<b>22c. NAME OF CEMETERY OR CREMATORIUM</b> <u>Lee's Crematory</u>			<b>22d. LOCATION (City, town, or county)</b> <u>Wash. D C</u>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lee. Funeral Home</u>					<b>ADDRESS</b> <u>300. 4th. st N.E.</u>				
					<b>24a. REC'D BY REGISTRAR</b> <small>DATE</small> <u>DEC 29 '59</u>				
					<b>24b. REGISTRAR'S SIGNATURE</b> <u>C. L. H. &amp; H. K.</u>				

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DR. L. L. VERNON, B.I.O.A.

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adults

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

14015

Reg. Dist. No.

14045							
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>14 da.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Lanham</b>		d. STREET ADDRESS <b>7802 Cross St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Johanna</b>		First <b>L.</b>	Middle <b>Funk</b>	Last <b></b>	4. DATE OF DEATH <b>Dec. 31</b>	Month <b>19</b>	Day <b>59</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 31, 1892</b>	9. AGE (In years last birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS. Days <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William E. Emmerich</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta Demme</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <b>Carl V. Funk 7802 Cross St. Lanham, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>myocardial infarction, massive, acute</b> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>420.1</b> <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <b>DUE TO</b> <b>(c)</b> <b>Coronary Artery Disease &amp; coronary Occlusion</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/17</u> , 19 <u>59</u> , to <u>12/31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/31/59</u> , 19 <u>59</u> , and that death occurred at <u>8:40 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>5102 Annapolis Road</b> M.D. <b>Bladensburg, Md.</b>					
ACTUAL SIGNATURE <b>Barry Rosenberg</b>		DATE SIGNED <b>12/31/59</b>					
PHYSICIAN'S NAME (Type) <b>Barry Rosenberg.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-5-1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Howard Strong</b>		ADDRESS <b>3707 N. North Ave.</b>		24a. REC'D BY REGISTRAR <b>JAN 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Horne</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

14016

14046

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>137 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>36 Capitol Heights</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>817 58 th Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Edward</b>	Middle <b>B</b>	Last <b>Garrett</b>	4. DATE OF DEATH	Month <b>Dec.</b>	Day <b>28</b>	Year <b>1959</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 April 1901</b>	9. AGE (In years last birthday) <b>58 yrs.</b>	IF UNDER 1 YEAR Months <b>58</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.Govt</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Emmett Garrett</b>				14. MOTHER'S MAIDEN NAME <b>Emma Bruce</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>WW 2</b>	INFORMANT <b>Robina S. Garrett</b>	Address <b>Same as # 2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X B bronchopneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Encephalomalacia</b> <b>5 months</b>							
(c) <b>Cerebral arteriosclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Generalized arteriosclerosis</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 1957</b> , to <b>Dec. 28th, 1959</b> that I last saw the deceased alive on <b>28 Dec., 1959</b> , and that death occurred at <b>3,454 M</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Peter Duus</b> M.D. <b>6117 Clearfield Drive</b> <b>Seat Pleasant, Md</b> DATE SIGNED <b>28 Dec. 59</b>							
ACTUAL SIGNATURE <b>Peter Duus</b>		PHYSICIAN'S NAME (Type) <b>Peter Duus., M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-31-59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington Motel</b>		22d. LOCATION (City, town, or county) (State) <b>2 X Myer, Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>K. G. Matternig</b>		ADDRESS <b>131-114 St. S.E.</b>		24a. REC'D BY REGISTRAR <b>DEC 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

لهم إني أنت عبدي  
أنت مالك كل شيء  
لا إله إلا أنت  
فإذن برحمتك

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
 may be retained by the hospital or attending physician and completely filled in by the funeral director.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 FilmG 53 12-29-59 et

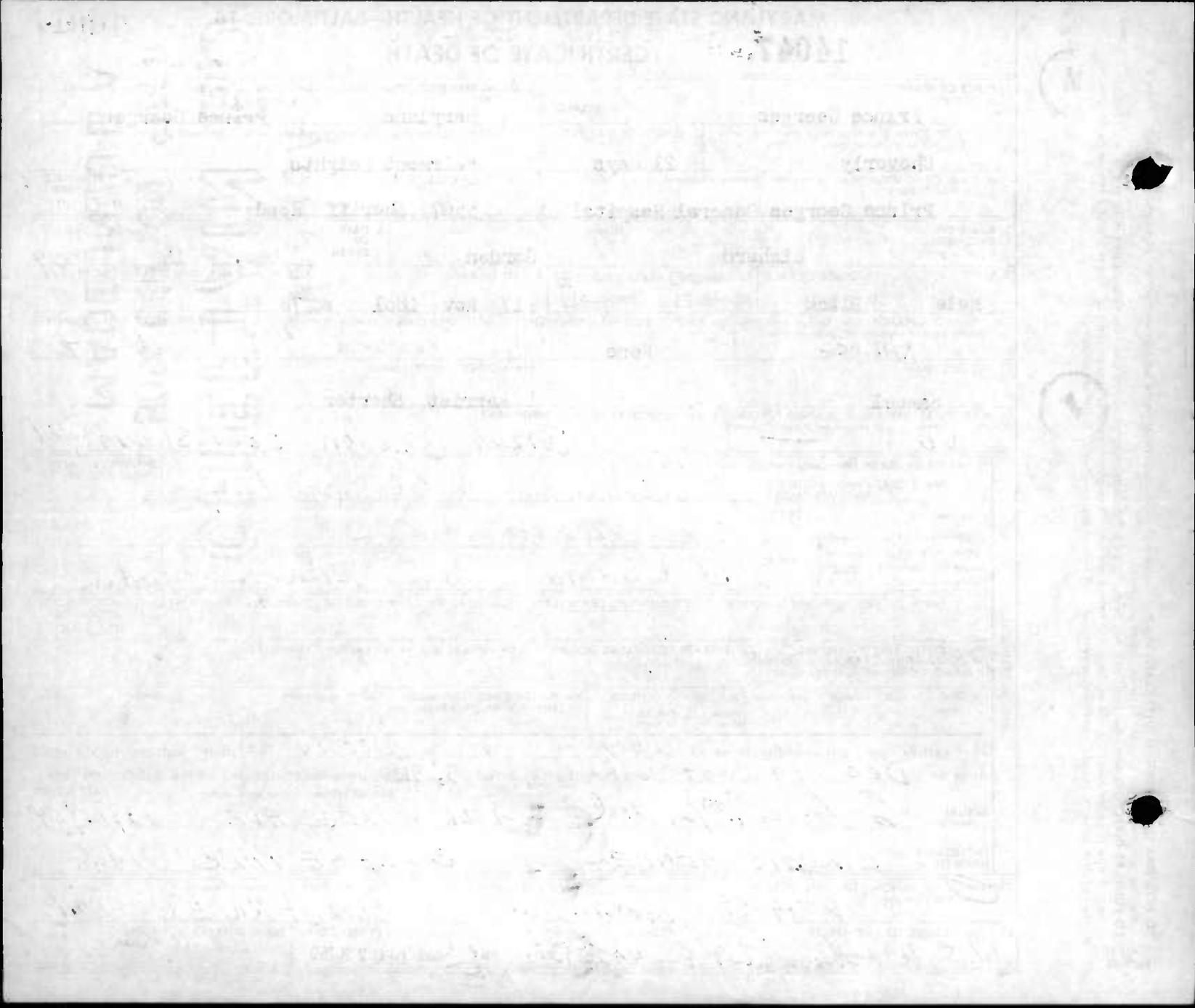
**14047**

14017

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>21 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Richard</b>	Middle	Last <b>Gordon</b>
4. DATE OF DEATH	Month <b>Dec.</b>	Day <b>14</b>	Year <b>19 59</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 Nov 1881</b>
9. AGE (In years last birthday) <b>78 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	11. KIND OF BUSINESS OR INDUSTRY <b>None</b>	12. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Samuel</b>	14. MOTHER'S MAIDEN NAME <b>Harriet Shorter</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>—</b>	INFORMANT <b>Sarah Gordon</b>	Address <b>5507 Sheriff Rd</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.3</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Pulmonary emboli rh lungs</b> (c) <b>Carcinomatosis</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Ca due cancerous &amp; fibrous of colon</b> DUE TO			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov</b> , 19, to <b>Dec 14</b> , 1959, that I lost sow the deceased alive on <b>Dec 14</b> , 1959, and that death occurred at <b>5:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. Louis Mendel</b>	ADDRESS (Street, city or town, state) <b>M.D. 4506 COLLEGE AVE COLLEGE PARK MD.</b>		
PHYSICIAN'S NAME (Type) <b>C. LOUIS MENDEL</b>	DATE SIGNED <b>12/15/59</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-19-59</b>	22b. DATE THEREOF <b>12-19-59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Harmony</b>	22d. LOCATION (City, town, or county) <b>Sheriff Rd Ex. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.S. Washington &amp; Son 49257 Don Ave</b>	ADDRESS <b>N.E.</b>	24a. REC'D BY REGISTRAR DATE <b>DEC 22 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Moore</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14918

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Prince George</i> MARYLAND		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Rural</i> 52 yrs	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>41 Laurel</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>325 Main street</i>		d. STREET ADDRESS <i>325 Main St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Vincent</i>	Middle <i>Greco</i>
Last <i>(GRECO)</i>		4. DATE OF DEATH <i>Dec. 12 1959</i>	Month Day Year
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH <i>April 15 1885</i>	
9. AGE (In years last birthday) yrs. <i>74</i>		IF UNDER 1 YEAR Months <i>3</i>	IF UNDER 24 HRS. Days <i>10</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Barker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own barbershop</i>	11. BIRTHPLACE (State or foreign country) <i>Italy</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Beney Greco</i>		14. MOTHER'S MAIDEN NAME <i>Rose Faro</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)	
17. INFORMANT <i>Mrs Theresa Greco Laurel Md</i>		Address <i>325 Main St</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary thrombosis</i> . DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH	
(b) <i>coronary thrombosis</i> DUE TO			
(c) <i>coronary thrombosis</i> .			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on <i>12-11 1959</i> , and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>ADDRESS</i> DATE SIGNED <i>12-11 1959</i>			
ACTUAL SIGNATURE <i>Idolo Pierandrei</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>IDOLO PIERANDREI</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/15/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>New-Cathedral Cem</i>
22d. LOCATION (City, town, or county) <i>Baltimore Md</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Re Wilt Sanderson, Laurel Md</i>		24a. REC'D BY REGISTRAR <i>DEC 17 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>
VS A15 (4) 15M 10/57			

AT 39015-00000-00000-00000 STATE OF CALIFORNIA

14019

## **CERTIFICATE OF DEATH**

**Reg. Dist. No.**

0401

14020

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

14103

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Upper Marlboro</i>		c. LENGTH OF STAY IN 1b <i>30 years</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Goodwood Farm</i>		e. STREET ADDRESS <i>Rte 1 Box 63</i>	
3. NAME OF DECEASED (Type or print) <i>Carter Francis Hall</i>		4. DATE OF DEATH Last <i>Dec</i> Month <i>15</i> Day <i>1959</i>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>April 27, 1890</i>
9. AGE (In years from birthday) <i>69 yrs.</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Solicitor</i>	10b. IN COUNTRY OF BIRTH <input checked="" type="checkbox"/> 10c. BIRTHPLACE (State or foreign country) <i>Tennessee</i>
11. IF UNDER 1 YEAR Months <i>11</i> Days <i>5</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Nicholas Andrew Hall</i>		14. MOTHER'S MAIDEN NAME <i>Estelle Gillin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-22-9839A</i>	
17. INFORMANT Address <i>Mrs. Catherine E. Hall, same as above</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive heart failure</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardiovascular renal disease</i>			
DUE TO <i>442x</i>			
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</i>			
DUE TO <i>(b)</i>			
(c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>(County) (State)</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>James I. Boyd</i>		DATE SIGNED <i>Dec 15, 1959</i>	
EXAMINER'S NAME (Type) <i>James I. Boyd</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/18/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Carmel Cemetery</i>		22d. LOCATION (City, town, or county) <i>(State) Upper Marlboro, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ritchie Bros. Funeral Home - Marlboro, Md.</i>		ADDRESS <i>Upper</i>	
VS. A15ME(5) 5M 9/55		24a. REC'D BY REGISTRAR DATE <i>DEC 21 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hunt</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14921

Reg. Dist. No.

## CERTIFICATE OF DEATH

14050

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>	c. LENGTH OF STAY IN 1b <b>2 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>5707 Seminole St</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's Hospital</b>		d. STREET ADDRESS <b>Berwyn Heights, Md.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle William	Last Hall
4. DATE OF DEATH	Month DEC	Day 1	Year 1959
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept 3, 1876
9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Maintenance</b>	11. BIRTHPLACE (State or foreign country) <b>Md</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Hall</b>	14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>no</b>	INFORMANT <b>Mildred H Campbell</b>	Address <b>Los Angeles California.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Nov 27, 1959</b> , to <b>Dec 1, 1959</b> , that I lost saw the deceased alive on <b>Nov 30, 1959</b> , and that death occurred at <b>23 M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>W.L. ETIENNE</b> PHYSICIAN'S NAME (Type) <b>W.L. ETIENNE</b> ADDRESS (Street, city or town, state) <b>4713 - BERWYN Rd, College Pk, Md.</b> DATE SIGNED <b>12-1-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/3/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Fort Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>	ADDRESS <b>Hyattsville Md.</b>	24a. REC'D BY REGISTRAR DATE <b>DEC 3 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14051

## CERTIFICATE OF DEATH

Reg. Dist. No.

14023

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	b. COUNTY <b>Prince George</b>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) ORGANIZATION <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>6311 60th Ave.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <b>Mark</b>	Middle <b>Edward Jr.</b>	Last <b>Hansford</b>	4. DATE OF DEATH <b>Dec. 17</b>	Month	Day	Year <b>1959</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 10, 1959</b>	9. AGE (In years last birthday) yrs. <b>7</b>	IF UNDER 1 YEAR Months <b>7</b>	IF UNDER 24 HRS. Days <b>7</b>	Hours <b>0</b>	Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13. FATHER'S NAME <b>Mark Edward Hansford Sr.</b>	14. MOTHER'S MAIDEN NAME <b>Carole Jane Wombacker</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	INFORMANT <b>Hospital records</b>	Address <b>Cheverly Md.</b>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>763.0</b> DUE TO <b>Interstitial Pneumonitis</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Doy, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <b>12-10</b> , 19 <b>59</b> , to <b>12-17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-12</b> , 19 <b>59</b> , and that death occurred at <b>5:50A</b> M, from the causes and on the date stated above.				
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ADDRESS (Street, city or town, state)

DATE SIGNED

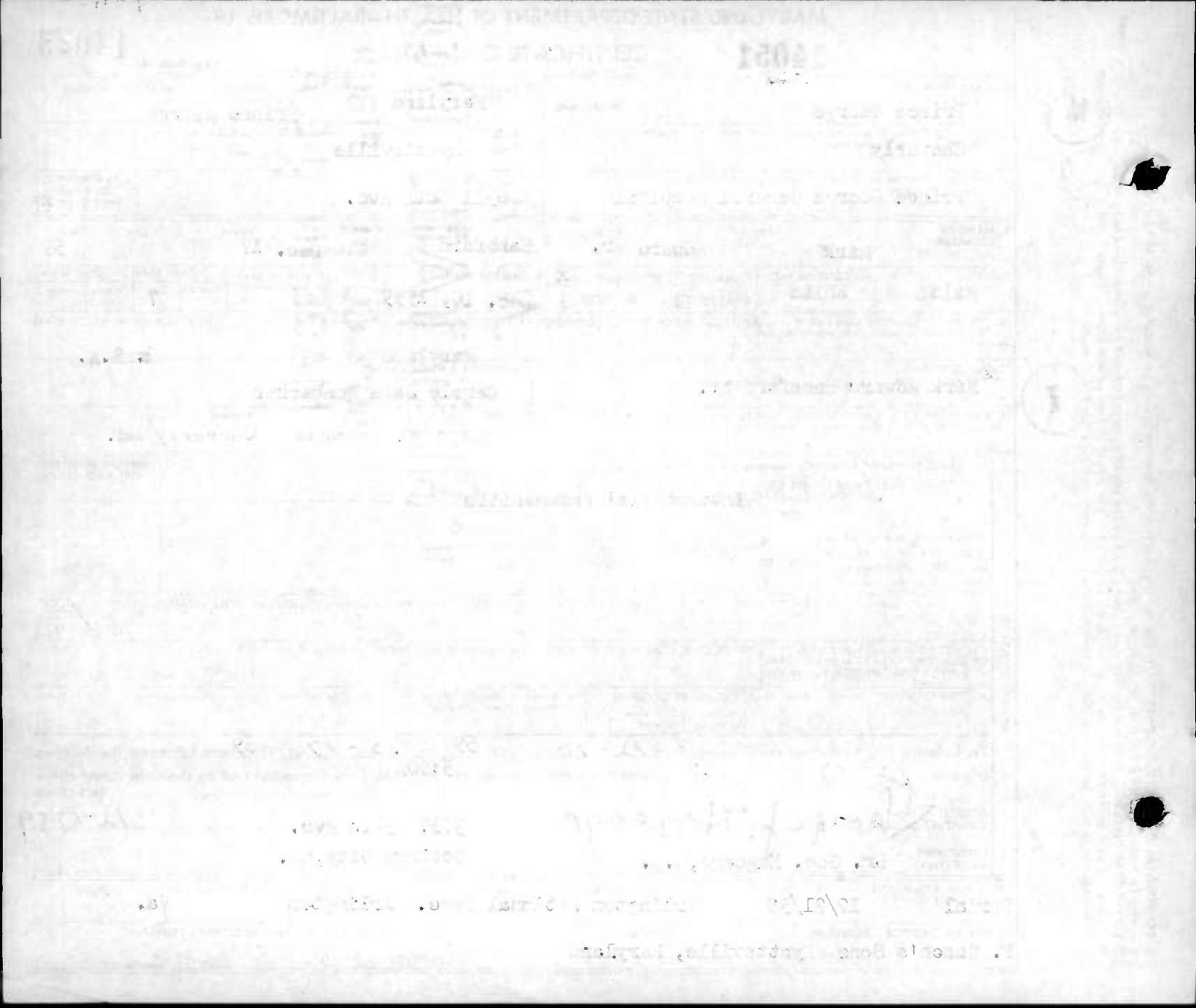
ACTUAL SIGNATURE <b>George J. Hageage</b>	M.D.	<b>3717 38th Ave.</b>	<b>12-17-59</b>
PHYSICIAN'S NAME (Type) <b>Dr. Geo. Hageage, M.D.</b>	Cottage City, Md.		

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/21/59</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Ceme.</b>	22d. LOCATION (City, town, or county) <b>Arlington</b> (State) <b>Va.</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>	ADDRESS <b>Hyattsville, Maryland</b>	24a. REC'D BY REGISTRAR DATE <b>DEC 23 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Carlton L. Thomas</b>
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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 3 should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death: Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 14024				
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie Md</b>					c. LENGTH OF STAY IN 1b <b>21 years</b>					b. COUNTY <b>Maryland</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1518 Chesnut avenue</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Bowie, Md.</b>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Agusta Elizabeth Harding</b>					First	Middle	Last	4. DATE OF DEATH <b>Dec 13, 1959</b>	Month	Day	Year			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 19, 1877</b>			9. AGE (In years last birthday) yrs. <b>82</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Treasurer Dept</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U S Government</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
13. FATHER'S NAME <b>John Reum</b>					14. MOTHER'S MAIDEN NAME <b>Annie Lyon</b>					Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Richard Reum</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>191.4</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b) DUE TO <b>Carcinomatosis hits Inguinal Metastasis to right lung</b>  (c) DUE TO <b>Carcinoma of Scalp</b>	INTERVAL BETWEEN ONSET AND DEATH <b>a year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arterosclerotic Heart Disease</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>R F D Bowie Md</b>	(County) <b>R F D Bowie Md</b>	(State) <b>12/13/59</b>
21. I certify that I attended the deceased from <b>12/12/59</b> to <b>12/13/59</b> , that I last saw the deceased alive on <b>12/12/59</b> , and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <b>R F D Bowie Md</b>				
ACTUAL SIGNATURE <b>H. James Kurtz</b>										DATE SIGNED <b>12/13/59</b>				
PHYSICIAN'S NAME (Type) <b>H. James Kurtz</b>		R F D Bowie, Md.												
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 16, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Fort Lincoln Cemetery</b>				22d. LOCATION (City, town, or county) <b>Colmar Manor, Md.</b>						
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>										ADDRESS <b>Hyattsville, Md.</b>				
24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>										24b. REGISTRAR'S SIGNATURE				
DATE DEC 17 '59														

01. ЗНОМІЛДЕ – ПІДАВАХРО ТІКІМІЗАВО СТАЦІЯ СІДІЛІРДІ

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2. See: Birth Cert. et

14105

## CERTIFICATE OF DEATH

14025

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>NONE</b> Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>		b. COUNTY <b>NONE/Maryland</b>	
c. LENGTH OF STAY IN 1b <b>25 HRS 24 MIN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Beach</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>		d. STREET ADDRESS <b>Albany &amp; Alabama Avenues</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>NEWBORN</b>	Middle <b>HAYMAN</b>	Last 4. DATE OF DEATH <b>DECEMBER</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>28 DECEMBER 1959</b>
9. AGE (In years lost birthday) yrs. <b>1</b>	10. IF UNDER 1 YEAR Months <b>1</b>	11. IF UNDER 24 HRS. Days <b>1</b>	12. Year Hours Min. <b>1959</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ROBERT L HAYMAN</b>		14. MOTHER'S MAIDEN NAME <b>HELEN J YORKLAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>22 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Premature birth</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>30 Dec</b> , 1959, to <b>29 Dec</b> , 1959, that I last saw the deceased alive on <b>0410 29 Dec</b> , 1959, and that death occurred at <b>0410 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>John A. Moore</b>		DATE SIGNED	
ACTUAL SIGNATURE <b>John A. Moore</b>		M.D. USAF HOSPITAL ANDREWS, ANDREWS AFB WASH 25 DC	
PHYSICIAN'S NAME (Type) <b>JOHN A. MOORE, CAPT, USAF, MC</b>		USAF HOSPITAL ANDREWS, ANDREWS AFB WASH 25 DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-31-59</b>		22b. DATE THEREOF <b>12-31-59</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>--</b>		22d. LOCATION (City, town, or county) <b>--</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hospital</b>		ADDRESS	
		24a. REC'D BY REGISTRAR DATE <b>JAN 4 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



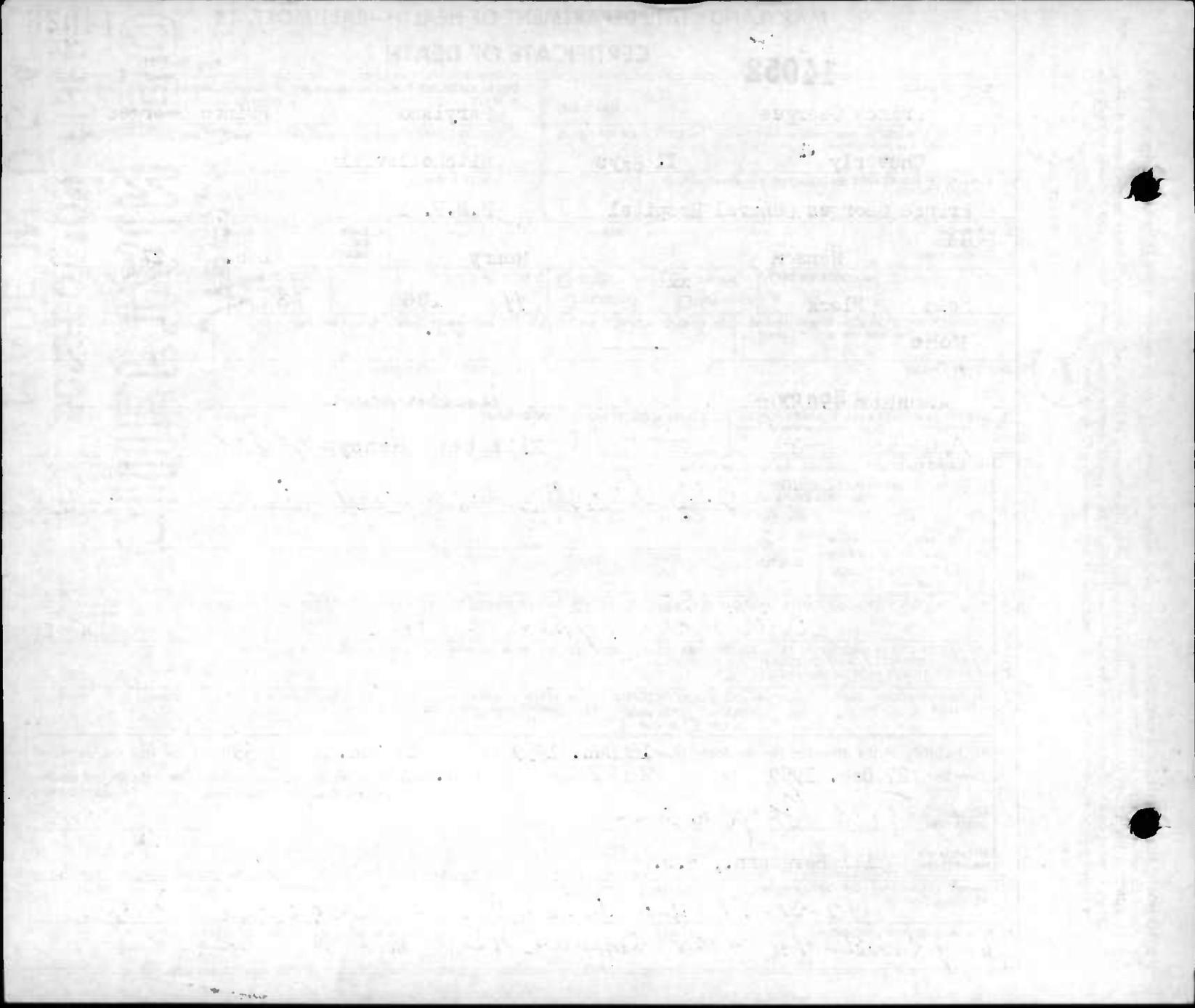
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14026

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL</b> and give nearest town <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Henson</b>	First	Middle	Last			
4. DATE OF DEATH <b>Henry</b>	Month	Day	Year			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1866</b>			
9. AGE (In years last birthday) <b>93</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Abraham Henry</b>	14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. —	INFORMANT <b>Elizabeth Henry - Wife</b>	Address —			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bacitrichopneumonia with abscess formation.</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic nephrosclerosis</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) ADDRESS (Street, city or town, state) —	(County)	(State)
21. I certify that I attended the deceased from <b>16 Dec. 1959</b> , 19_____, to <b>27 Dec. 1959</b> , 19_____, that I last saw the deceased alive on <b>27 Dec. 1959</b> , 19_____, and that death occurred at <b>6:50 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Till Bergmann</b> M.D. PHYSICIAN'S NAME (Type) <b>Till Bergmann, M.D.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-31-59</b>	22b. DATE THEREOF <b>12-31-59</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Holy Family Cem.</b>	22d. LOCATION (City, town, or county) <b>Woodlawn Md</b> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry J. Washington</b>		ADDRESS <b>4925 Dean Ave N.E.</b>	24a. REC'D BY REGISTRAR <b>JAN 4 1960</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14053

## CERTIFICATE OF DEATH

Reg. Dist. No. 14027

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>15 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Willard</b>	First <b>Dewey</b>	Middle <b>Hook</b>	4. DATE OF DEATH Month <b>Dec.</b> Day <b>25</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17, 1898</b>
9. AGE (In years last birthday) <b>61 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foremen</b>	11. KIND OF BUSINESS OR INDUSTRY <b>County Pub. Works</b>	12. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Samuel Pinkney Hook</b>	14. MOTHER'S MAIDEN NAME <b>Annie Eliza Duley</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown) <b>X Unkwn</b>	16. SOCIAL SECURITY NO. <b>123-45-6789</b>	INFORMANT <b>Emily Viola Hook -Same As Above.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>600.0</b> DUE TO <b>Uremia</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Chronic Bilateral Pyelonephritis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>7 Days</b>			
3 Mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1 hr</b> , 19 <b>59</b> , to <b>Dec. 25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>24 Dec</b> , 19 <b>59</b> , and that death occurred at <b>3:40 A.M.</b> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>Upper Marlboro, Md.</b>			
DATE SIGNED <b>12/25/59</b>			
ACTUAL SIGNATURE <i>Robert Sasscer</i>		PHYSICIAN'S NAME (Type) <b>Robert Sasscer, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/28/59</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Thomas Cemetery</b>		22d. LOCATION (City, town, or county) <b>Groom</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Itchie Bros. Funeral Home</i>		ADDRESS <b>Upper Marlboro, Md.</b>	
		24a. REC'D BY REGISTRAR <b>DEC 30 '59</b>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>	

82041



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14105 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14028

1. PLACE OF DEATH a. COUNTY	Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	d. STATE	e. COUNTY	
Brandywine	3 years	Maryland	Prince George's	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS			
Route 381	Brandywine Route 381			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Victor Arthur		Horton	Horton	Dec	16	1959	

5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov 26, 1907	52 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Road Builder	Road Builder	Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S M AIDEN NAME
Arthur R. Horton	Eva Crouch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	221-36-6471	Marieette Virgin Horton, son	+

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute congestive heart failure
442x	
DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
(b)	Cardiovascular renal disease
DUE TO	
(c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
----------------------------------------------------------------------------------------------------------------------------------	--	---------------------------------------------------------------------------------------------------

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

ACTUAL SIGNATURE James I. Boyd	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED Dec 16, 1959
EXAMINER'S NAME (Type) James I. Boyd	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-20-59	22c. NAME OF CEMETERY OR CREMATORIUM Fort Hill Cemetery	22d. LOCATION (City, town, or county) Lynchburg, Virginia	(State) —
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Esq., Washington, D.C.	ADDRESS	24a. REC'D BY REGISTRAR DEC 21 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

THE STATE OF MARYLAND  
DEPARTMENT OF DOMESTIC RELATIONS  
DIVISION OF CHILDREN AND YOUTH SERVICES

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14029

14054

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Prince Georges MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)  
a. STATE

Maryland

Prince Georges

## b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Laurel RURAL

## c. LENGTH OF STAY IN 1b

Mo. 22 days

## c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

41 Laurel (West)

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

Laurel Sanitarium

## d. STREET ADDRESS

Maple Ave.

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First Middle Last

4. DATE  
OF  
DEATHMonth Day Year  
December 20 1959

## 5. SEX

Female

## 6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

April 25, 1873

9. AGE (In years  
last birthday)  
86 yrs.IF UNDER 1 YEAR  
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Housewife

## 10b. KIND OF BUSINESS OR INDUSTRY

—

## 11. BIRTHPLACE (State or foreign country)

Washington D.C.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

James Reynolds

## 14. MOTHER'S MAIDEN NAME

Anne Cochren

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

(If yes, give war or dates of service)

—

## 16. SOCIAL SECURITY NO.

—

## INFORMANT

Mrs. C. Ostmann - Maple Ave.  
West Laurel - Maryland

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

332X

Cerebral Thrombosis

INTERVAL BETWEEN  
ONSET AND DEATH

Two weeks

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

## DUE TO

(b)

## DUE TO

(c)

General Arteriosclerosis

## Many years

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town) (County) (State)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. p. m.20d. INJURY OCCURRED  
While at work  Not while at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 18, 1959 to Dec. 20, 1959 that I last saw the deceased alive on Dec 19, 1959, and that death occurred at 12:15 P.M. from the causes and on the date stated above.

## ADDRESS (Street, city or town, state)

## DATE SIGNED

ACTUAL  
SIGNATUREPHYSICIAN'S  
NAME (Type)

Jesse C. Coggins M.D.

Laurel Sanitarium

12/20/59

22a. BURIAL, CREMATION,  
REMOVAL (Specify)  
Burial22b. DATE THEREOF  
12/23/5022c. NAME OF CEMETERY OR CREMATORIUM  
Mt Olivet Cem22d. LOCATION (City, town, or county)  
(State)  
Washington D. C.

## 23. FUNERAL DIRECTOR'S SIGNATURE

W. K. Huntemann &amp; Son

## ADDRESS

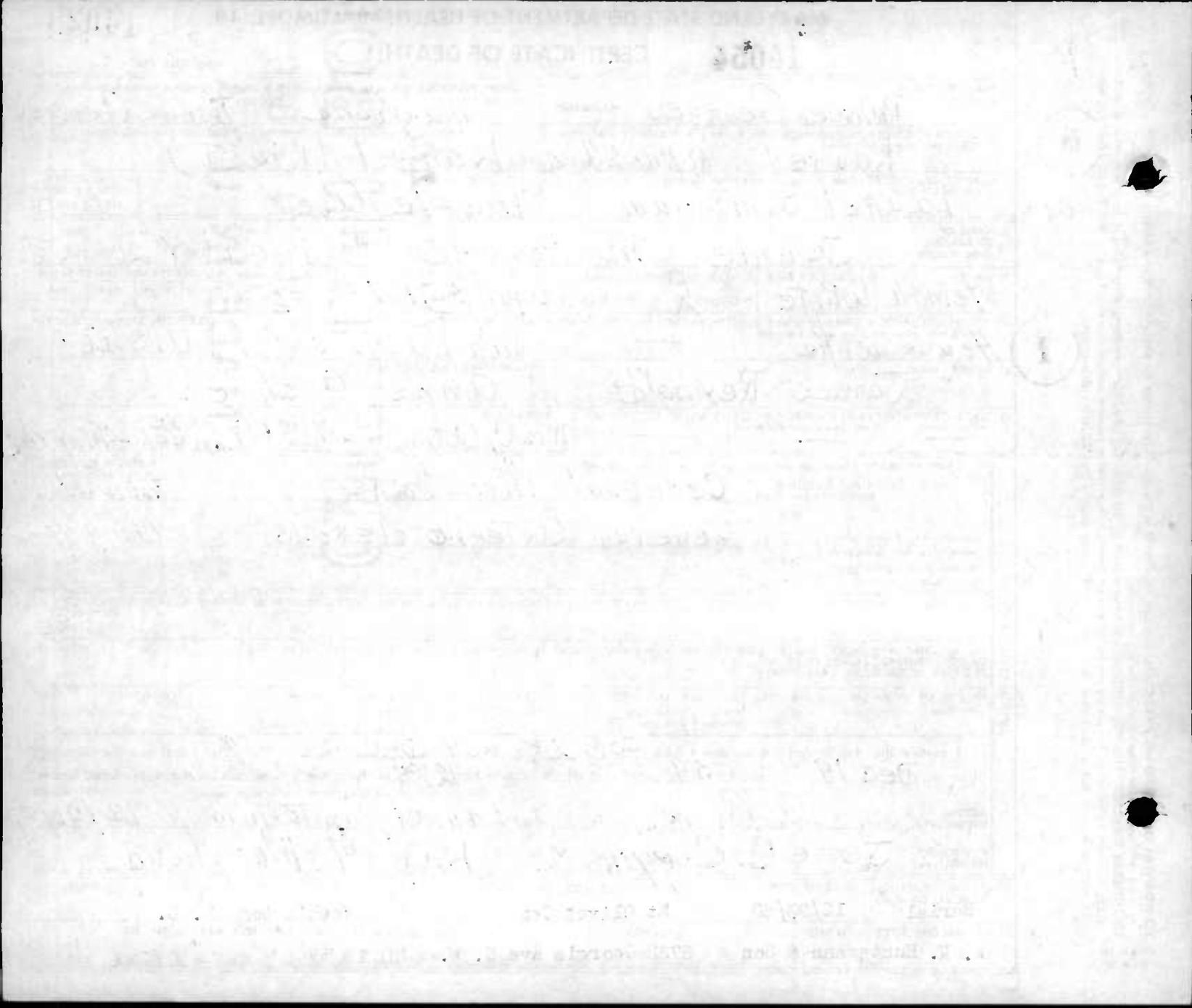
5732 Georgia Ave N. W.

## 24a. REC'D BY REGISTRAR

DEC 23 '59

## 24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

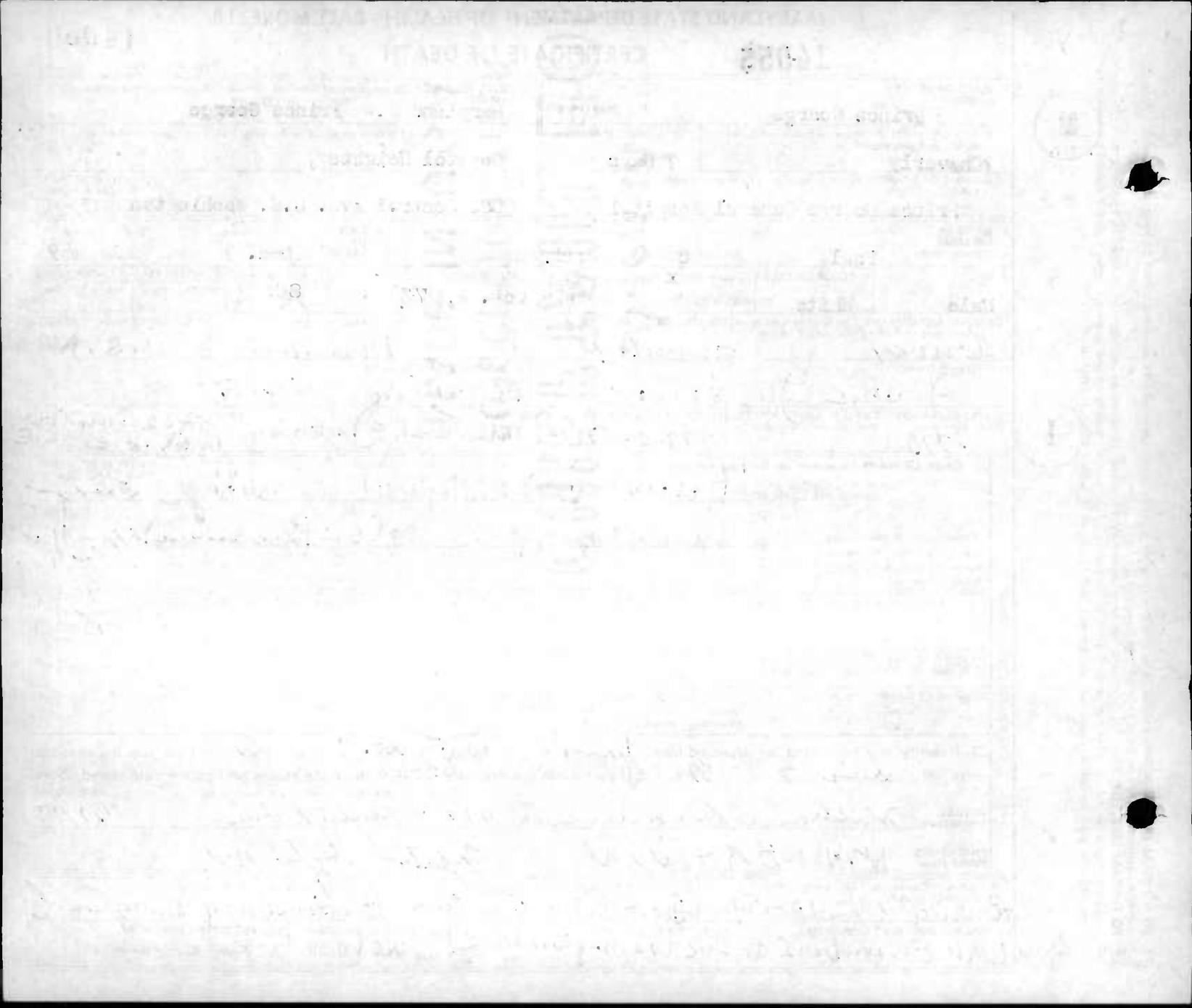
14055

## CERTIFICATE OF DEATH

Reg. Dist. No.

14050

1. PLACE OF DEATH o. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>7 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Capitol Heights,</b>		d. STREET ADDRESS <b>6802 Central Ave. S.E. Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Paul</b>	Middle <b>C</b>	Last <b>Jackman</b>	4. DATE OF DEATH	Month <b>Dec. 7</b>	Day	Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2, 1873</b>	9. AGE (In years long birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Gosha Jackman</b>		14. MOTHER'S MAIDEN NAME <b>Aurelia Hunt</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-09-5763A.</b>		INFORMANT <b>Mrs. Sarah E. Jackman</b>		Address <b>5802 Central Ave. Wash. D.C. S.E.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>6124 Central Ave.</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 1, 1959</b> to <b>Dec. 7, 1959</b> , that I last saw the deceased alive on <b>Dec. 7, 1959</b> , and that death occurred at <b>8:55 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William Brainin M.D.</b>							
PHYSICIAN'S NAME (Type) <b>WM BRAININ</b>							
ADDRESS (Street, city or town, state) <b>Capitol Heights, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-10-59</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) <b>Bladensburg Maryland</b>	
(State)							
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co Inc. Washington D.C.</b>							
ADDRESS							
24a. REC'D BY REGISTRAR DATE <b>DEC 10 '59</b>							
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14031

14056

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		COUNTRY <b>Prince George</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Everly</b>		c. LENGTH OF STAY IN lb <b>7 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>		d. STREET ADDRESS <b>5107 Edgewood Road</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Baby</b>	Middle <b>Boy</b>	Last <b>John Carroll</b>	4. DATE OF DEATH <b>Dec. 1</b>	Month <b>Dec.</b>	Day <b>1</b>	Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	b. DATE OF BIRTH <b>Nov. 25, 1959</b>	9. AGE (In years lost birthday) — yrs. <b>— yrs.</b>	IF UNDER 1 YEAR Months <b>18</b>	IF UNDER 24 HRS. Days <b>20</b>	Hours <b>18</b>	Min. <b>20</b>
8. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None--Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Eugene Jackson</b>			14. MOTHER'S MAIDEN NAME <b>Barbara Ann Sparrough</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>			INFORMANT <b>Mother Barbara Ann Jackson, 5107 Edgewood Rd.,</b>		
Address <b>College Park, Md.</b>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO <b>762.5</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Obstruction</b> DUE TO (c) <b>with secondary &amp; early onset of heart failure prenatally</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Nov. 25</b> , 19 <b>59</b> , to <b>Dec. 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/1</b> , 19 <b>59</b> , and that death occurred at <b>89</b> M, from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>6905 Reata Blvd, College Park, Maryland</b>								
DATE SIGNED <b>12/1/59</b>								
ACTUAL SIGNATURE <b>Thomas A. Christensen</b>								
PHYSICIAN'S NAME (Type) <b>Dr. Thomas A. Christensen</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/2/1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Prince George's Co., Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>								
ADDRESS <b>2077245XU2</b>								
24a. REC'D BY REGISTRAR <b>DEC 3 1959</b>								
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Traub</b>								

260A

DATA SOLID

DATA

DATA

DATA

DATA SOLID

DATA SOLID

DATA SOLID

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DATA

DATA

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14057

## CERTIFICATE OF DEATH

Reg. Dist. No. 14032

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>14 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>		d. STREET ADDRESS <b>P.O. Box 62</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Robert</b>		First <b>Lee</b>	Middle <b>Jett Jr.</b>	Last	4. DATE OF DEATH Month <b>Dec.</b> Day <b>12</b> Year <b>1959</b>	Month <b>Dec.</b>	Day <b>12</b>	Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 28, 1959</b>		9. AGE (In years last birthday) yrs. <b>14</b>	IF UNDER 1 YEAR Months <b>14</b>	IF UNDER 24 HRS. Days <b>14</b>	Hours <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>---</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Robert Lee Jett, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Jo Ann Clendenin</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>		INFORMANT <b>Mother Jo Ann Clendenin</b>		Address Same as <b>Mother Jo Ann Clendenin - above.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>760.5</b> DUE TO <b>patchy atelectasis -</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>inter-cranial hemorrhage, old</b> ? (c) <b>prematurity (weight 1200 gm L. 41 cm)</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Rivervale, Maryland</b>		(State)
21. I certify that I attended the deceased from <b>Nov. 28, 1959</b> , to <b>Dec. 12 1959</b> , that I last saw the deceased alive on <b>Dec. 12, 1959</b> , and that death occurred at <b>1:30PM</b> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>William A. Stecker M.D.</b> ADDRESS (Street, city or town, state) <b>6300 Riverdale Rd.</b> DATE SIGNED <b>12/12/59</b>								
PHYSICIAN'S NAME (Type) <b>William A. Stecker M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/14/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Trinity Cemetery</b>			22d. LOCATION (City, town, or county) <b>Upper Marlboro, Md.</b>			(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Felicie Bass - Upper Marlboro, Md.</b>								
ADDRESS <b>207 117 IX W</b>								
24a. REC'D BY REGISTRAR DATE <b>DEC 16 '59</b>								
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>								

CHURCH OF CHRIST



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
CERTIFICATE OF DEATH											
Reg. Dist. No. 14053											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DC b. COUNTY ✓							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AOSACORTIDES REST HOME				d. STREET ADDRESS 5510 16th St NW				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First BERTHA	Middle BARTELS	Last JOHNSON	4. DATE OF DEATH DEC 21	Month	Day	Year	1959		
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH NOV. 13, 1875	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) WASHINGTON DC			
12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME ? BARTELS				14. MOTHER'S MAIDEN NAME LOUISE M ?							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO				16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO Uremia INTERVAL BETWEEN ONSET AND DEATH 3 days.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cerebral hemorrhage 10 days (c) DUE TO											
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. p.m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8/1/59, to 12/21, 1959, that I last saw the deceased alive on 12/20/1959, and that death occurred at 5115A, from the causes and on the date stated above.											
ACTUAL SIGNATURE F.E. MUSSER M.D. ADDRESS (Street, city or town, state) 4410 74th Ave NW, Washington, DC DATE SIGNED 12/21/59											
22a. BURIAL, CREMATION, REMOVALS (Specify) 12-23-59				22c. NAME OF CEMETERY OR CREMATORIAL GLENWOOD				22d. LOCATION (City, town, or county) (State) WASHINGTON D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Deaf Funeral Home				ADDRESS 4812 Ga. Ave. Wash. D.C.				24a. REC'D BY REGISTRAR DATE DEC 28 '59			
VS A15 (4) 15M 9/55								24b. REGISTRAR'S SIGNATURE Arthur S. Krause			



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
Items 2, 7, & 9 - Film G254-1/6/60-mb  
**CERTIFICATE OF DEATH** Items 8, 9, 13, 14 - Film G254 1-8-60 et  
Reg. Dist. No. 141034

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Clinton</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dorsey Road SE</i>		c. LENGTH OF STAY IN 1b <i>Unknown</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince George's County Rest Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton</i>	
3. NAME OF DECEASED (Type or print) <i>Charles</i>		f. STREET ADDRESS <i>St. John's Catholic Church</i>	
3. NAME OF DECEASED (Type or print) <i>Charles</i>		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
4. SEX <i>Male</i>		5. COLOR OR RACE <i>Colored</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7. DATE OF BIRTH <i>Unknown</i>		8. DATE OF DEATH <i>Dec 27 1959</i>	
9. AGE (In years lost birthday) <i>75 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Custodian</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cleaning</i>	
10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown ??</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i> Margaret Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Hospital Records</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>571.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Acute non Specific Colitis</i> DUE TO (c) <i>General Arteriosclerosis (Senile)</i> unknown	
		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>natural causes</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Unknown</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5440 Silver Hill Rd SE</i>
20f. (City or town) <i>Washington 28 DC</i>		(County) <i>Clinton</i> (State) <i>MD</i>	
21. I certify that I attended the deceased from <i>Sept 1st 1959</i> to <i>Dec 27 1959</i> , that I last saw the deceased alive on <i>Dec 26 1959</i> , and that death occurred at <i>5440 Silver Hill Rd SE</i> M.D., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Washington 28 DC</i> DATE SIGNED <i>Paul C. Van Vatta</i> <i>12-30-59</i>	
ACTUAL SIGNATURE <i>Paul C. Van Vatta</i>		PHYSICIAN'S NAME (Type) <i>Paul C. Van Vatta</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-30-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. John</i>
22d. LOCATION (City, town, or county) <i>Clinton</i>		(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Myrtle K. Gilliland</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 31 1959</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Trahan</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG254 1-4-60 et

14055

## CERTIFICATE OF DEATH

Reg. Dist. No.

14013

## 1. PLACE OF DEATH

o. COUNTY

PRINCE George

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hyattsville

c. LENGTH OF STAY IN lb

2 yr.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

CARROLL Manor

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington D.C. 47X-3

d. STREET ADDRESS

1761 MASS. AVE. N.W.

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATHMonth  
DecDay  
28  
Year  
1959

5. SEX

Female

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

Oct. 3 - 1874

9. AGE (In years  
last birthday)  
85 yrs.10. IF UNDER 1 YEAR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MILLINCY

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, MD, USA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

FRANKLIN A Neal

14. MOTHER'S MAIDEN NAME

HANNAH V. SALIGE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

INFORMANT

Address

SR. Maureen Therese - Carroll Manor

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

585 X

DUE TO

CORONARY THROMBOSIS &amp; MYOCARDIAL INFARCTION 3 days

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.{ (b)  
DUE TO  
(c)

CHOLECYSTITIS 2 months

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year  
Hour a.m. p.m. 19 20d. INJURY OCCURRED  
While at work  Not while at work  20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.) 20f. (City or town)  
(County) (State)21. I certify that I attended the deceased from MAR 36, 1959, to DEC 28, 1959, that I last saw the deceased  
alive on DEC 27, 1959, and that death occurred at 77 M, from the causes and on the date stated above.  
ADDRESS (Street, city or town, state) DATE SIGNEDACTUAL  
SIGNATURE

Thomas F Collins

M.D.

322-H 0 NE

12/28/59

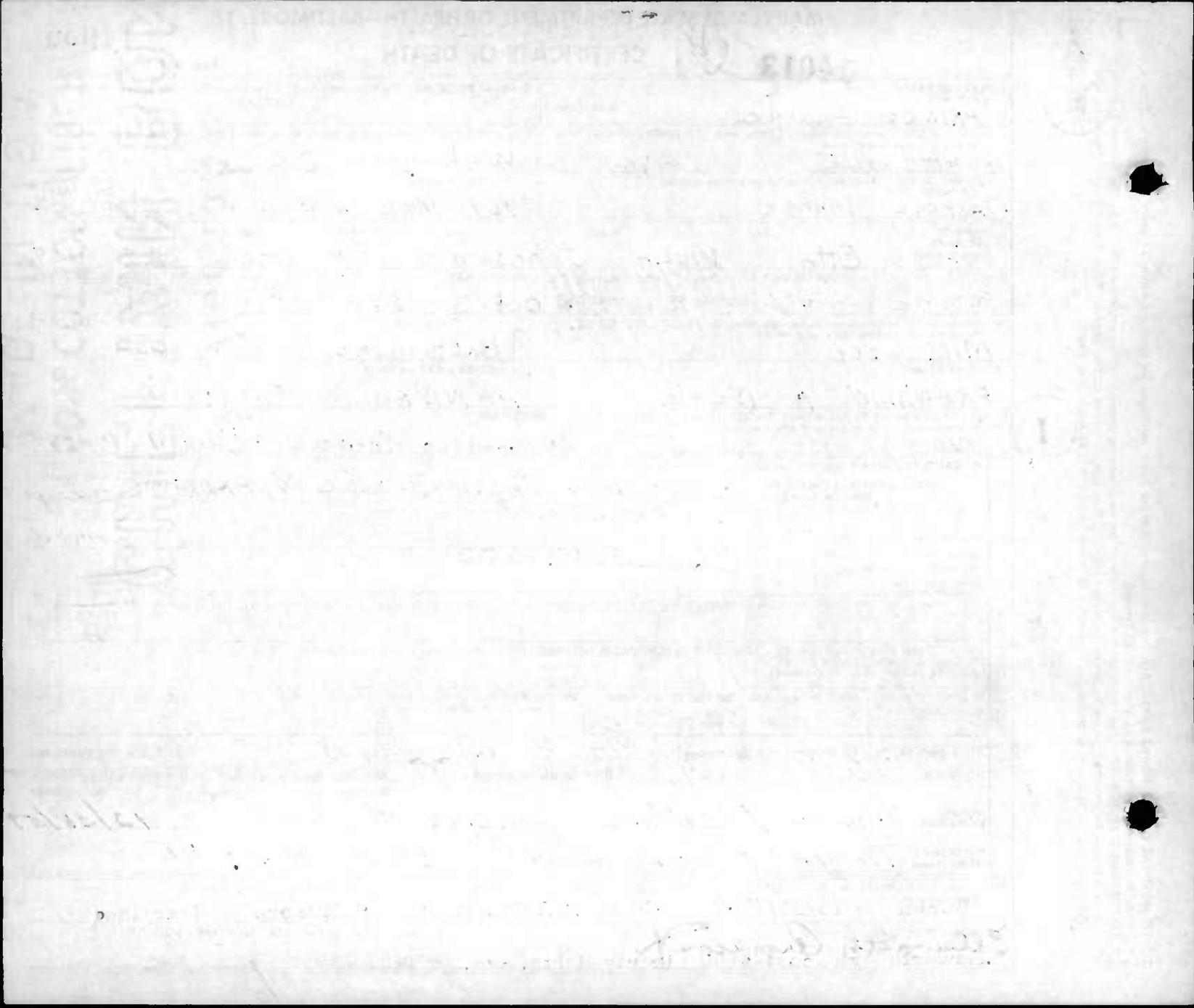
PHYSICIAN'S  
NAME (Type)

THOMAS F COLLINS MD

322-H ST NE

22a. BURIAL, CREMATION,  
REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM 22d. LOCATION (City, town, or county) (State)  
Burial 12/31/1959 Cedar Hill Cemetery Baltimore Maryland23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE  
Ellsworth Armacost 4600 Liberty Hghts. Ave. DATE DEC 30 '59 Charles E. Kline

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14060

## CERTIFICATE OF DEATH

Reg. Dist. No.

14036

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rivertowne</b>		c. LENGTH OF STAY IN 1b <b>app. 50 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eugene Leland Memorial Hospital</b>		d. STREET ADDRESS <b>327 Thomas Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>THOMAS</b>		First <b>L.</b>	Middle <b>JOHNSTON</b>	Last	4. DATE OF DEATH <b>December 28 1959</b>	Month	Day	Year
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>5/6/1892</b>	9. AGE (In years lost birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
8. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Model maker U.S. government</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Leasure Johnston</b>		14. MOTHER'S MAIDEN NAME <b>Hamah Rouch</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital records</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2041</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>				
21. I certify that I attended the deceased from _____, to _____, that I last saw the deceased alive on _____, and that death occurred at _____ M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b> DATE SIGNED <b>Dec 28 1959</b>		
ACTUAL SIGNATURE <b>R.C. Wingfield, M.D.</b>								
PHYSICIAN'S NAME (Type) <b>R.C. Wingfield, M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 12/31/59</b>		22b. DATE THEREOF <b>12/31/59</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Otis Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Knott</b>		ADDRESS <b>Laurel, Md.</b>		24. REC'D BY REGISTRAR DATE JAN 4 '60		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knott</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

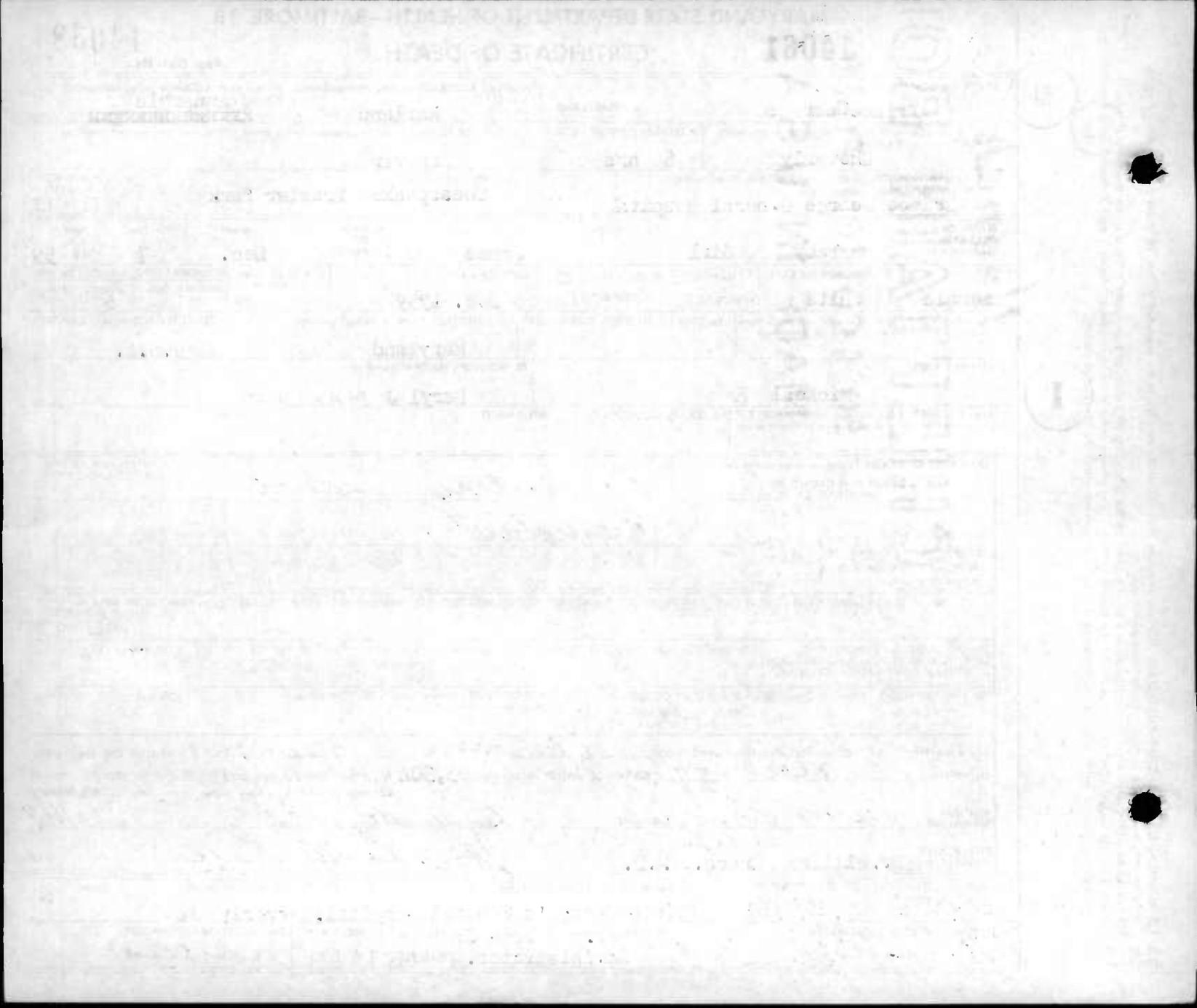
BY DEDICATION—MEMORIAL OF THE UNITED STATES CHARTER

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 14061 CERTIFICATE OF DEATH										14038	
										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY		Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE		b. COUNTY Andardale	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cheverly		c. LENGTH OF STAY IN 1b 6 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Maryland		02X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Prince George General Hospital				d. STREET ADDRESS		Cheasapeake Trailer Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Baby	Middle Girl	Last Jones	4. DATE OF DEATH	Month Dec.	Day 7	Year 19 59			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6 Dec. 1959	6	6	6	6	6		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
						Maryland			U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					Address	
Micheal E=					Beryl J MARSHIO						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT		INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
773.5 Respiratory Failure											
DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)											
DUE TO											
(c) Prenaturity											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that I attended the deceased from 6 Dec. 1959, to 7 Dec. 1959, that I last saw the deceased alive on 7 Dec. 1959, and that death occurred at 3:30A M, from the causes and on the date stated above.											
ADDRESS (Street, city or town, state)											
M.D. Hyattsville Md											
ACTUAL SIGNATURE Dr. William Greco											
PHYSICIAN'S NAME (Type) Dr. William Greco, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 12/9/59		22c. NAME OF CEMETERY OR CREMATORIY Prince George's General Hospital, Cheverly		22d. LOCATION (City, town, or county) Md		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Harry W Penn Jr Administrator.		24a. REC'D BY REGISTRAR DATE DEC 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

14037

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>	c. LENGTH OF STAY IN 1b <b>5 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, DC</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>		d. STREET ADDRESS <b>1633 MORRIS ROAD, SE</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>ANTHONY</b>	First <b>L</b>	Middle <b>JONES</b>	4. DATE OF DEATH <b>DECEMBER 9 1959</b>	Month Day Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGROID</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 NOVEMBER 1959</b>	9. AGE (In years last birthday) yrs. <b>18</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>
13. FATHER'S NAME <b>JARVIS J. JONES</b>		14. MOTHER'S MAIDEN NAME <b>ARDELLE L. LAWRENCE</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	17. INFORMANT <b>FATHER</b>	Address <b>SAME AS 2d</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>571.0</b> DUE TO Septicemia		INTERVAL BETWEEN ONSET AND DEATH <b>19 hrs</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Diarrhea		<b>2 weeks</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>USAF HOSPITAL ANDREWS</b> DATE SIGNED <b>9 DECEMBER 1959</b>		
ACTUAL SIGNATURE <b>Vincent P Ringrose, Jr.</b>		M.D.		
PHYSICIAN'S NAME (Type) <b>VINCENT P RINGROSE, JR, CAPT, USAF, MG</b>		USAF HOSPITAL ANDREWS, WASHINGTON 25, DC		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-12-59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>PLEASANT PLAINS</b>	22d. LOCATION (City, town, or county) <b>AHOSKIE</b> (State) <b>NORTH CAROLINA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. F. Taylor</b>		ADDRESS <b>1702 12TH ST, N.W. D.C.</b>	24a. REC'D BY REGISTRAR DATE <b>DEC 14 '59</b>	24b. REGISTRAR'S SIGNATURE <b>O. Smith S. Times</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me, funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Date of Death

County

Name

Cause of Death

Address

City

State

Zip

Phone Number

Relationship

Age

Sex

Race

Height

Weight

Color of Hair

Color of Eyes

Occupation

Employer

Employment Status

Employment Type

Employment Industry

Employment Address

Employment City

Employment State

Employment Zip

Name

Cause of Death

Address

Cause of Death

Name

Cause of Death

Signature \_\_\_\_\_

Title \_\_\_\_\_

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14033

Reg. Dist. No.

14014

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>MARYLAND Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>8 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4100 Oglethorpe Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS <b>4100 Oglethorpe Street</b>	
3. NAME OF DECEASED (Type or print)	First <b>Frank</b>	Middle <b>Jacob</b>	Last <b>Kiess</b>
4. DATE OF DEATH	Month <b>December</b>	Day <b>1, 19</b>	Year <b>59</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-26-88</b>
9. AGE (In years last birthday) <b>71 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William Kiess</b>		14. MOTHER'S MAIDEN NAME <b>Ellen L. Fehr</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>W.W.1</b>	17. INFORMANT <b>Ellen S. Kiess; same address as # 2.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442x</b> DUE TO <b>Acute congestive heart failure</b> INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiovascular renal disease</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>	DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 2, 1959		
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/3/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Ft Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>	24a. REC'D BY REGISTRAR DATE <b>DEC 4 '59</b>
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**14062 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14062

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Prince George's MARYLAND		a. STATE Maryland Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Riverdale Dead man's house		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		3. STREET ADDRESS 36 Capital Heights 1822-59th Avenue	
Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Henry Lee King		Last	4. DATE OF DEATH Dec 19 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb 21, 1925
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Plumber	
Plumber		11. BIRTHPLACE (State or foreign country) District of Columbia U. S. A.	
13. FATHER'S NAME William Rufus King		14. MOTHER'S MAIDEN NAME Laurel Ethel Walton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 579-10-5998	
17. INFORMANT Helen M. Boyd upper more below		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0 DUE TO Shock.		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Universal burns body, second degree			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was sleeping in room that caught fire	
20c. TIME OF INJURY Month, Day, Year Nov. 12-14 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Capital Heights, D. C.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED Dec 19, 1959	
EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, Cremation or other disposition (Specify) Burial		22b. DATE THEREOF Dec 23, 1959.	
22c. NAME OF CEMETERY & BURIAL ADDRESS Arlington National Cemetery Riverdale, Maryland.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.,		24a. REC'D BY REGISTRAR DATE DEC 28 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MANHATTAN-STATEN ISLAND DEPARTMENT OF HUMAN-SERVICES

18

JUDGE'S CERTIFICATE OF DEATH

1808

DECEASED

NAME	ADDRESS	AGE	SEX	CAUSE OF DEATH	TIME OF DEATH	TIME OF EXAMINATION	TIME OF CERTIFICATION
JOHN J. O'LEARY	100-12TH AVENUE	50	MALE	HEART DISEASE	10:00 A.M.	10:00 A.M.	10:00 A.M.
EXAMINER'S STATEMENT I, JOHN J. O'LEARY, a physician, examined the body of JOHN J. O'LEARY, deceased, at 10:00 A.M. on October 18, 1968, and found him to be dead. I certify that he died of heart disease.							
SIGNED AND DATED John J. O'Leary, M.D. October 18, 1968							

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14041

14063

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		M		X				
14063		CERTIFICATE OF DEATH						
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>12 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>		d. STREET ADDRESS <b>P.O. Box Box 366</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Betty = Pauline</b>		First	Middle	Lost	4. DATE OF DEATH <b>Dec. 8</b>	Month	Doy	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 June 1938</b>	9. AGE (In years last birthday) <b>21 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction Co</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Herman Knauer</b>				14. MOTHER'S MAIDEN NAME <b>Ruth B Wilson</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		INFORMANT		Address <b>Herman Knauer Beltsville, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive left ventr. hemor.</b> DUE TO <b>Sub acute bacterial endocarditis</b> INTERVAL BETWEEN ONSET AND DEATH <b>414X</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Rheumatic heart disease</b> (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Dec 8, 1959</b>		(County) <b>Dec 8, 1959</b> (State) <b>MD</b>
21. I certify that I attended the deceased from <b>Oct 1959</b> , to <b>Dec 8, 1959</b> , that I last saw the deceased alive on <b>Dec 8, 1959</b> , and that death occurred at <b>7:40 A.M.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Dr. W. Etienne</b>		ADDRESS (Street, city or town, state) <b>4713 Terwyn Rd, College Park, Md.</b> DATE SIGNED <b>14/8/59</b>						
PHYSICIAN'S NAME (Type) <b>Dr. W. Etienne, Md.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 10, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Trinity Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) <b>Bowie Md.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knauer</b>		

63041

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14042

## CERTIFICATE OF DEATH

Reg. Dist. No.

14064

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg Md.</b>		c. LENGTH OF STAY IN 1b <b>15 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4101 55th avenue</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>33 Bladensburg Md.</b>	
3. NAME OF DECEASED (Type or print) <b>HENRY</b>		4. DATE OF DEATH <b>A. KNEFELY</b>	
First <b>MALE</b>		Middle <b>LAST</b>	
6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <b>JAN 3, 1889</b>		9. AGE (In years last birthday) <b>70 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor Forman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>University of Md</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles Knefely</b>		14. MOTHER'S MAIDEN NAME <b>Mary E Leighsier</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. INFORMANT <b>Mildred K Belvin</b>	
17. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Hypertensive Cardiovascular</b> DUE TO <b>Disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b> (County) <b>Baltimore</b> (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>July</b> , 1956, to <b>Dec 25</b> , 1959 that I last saw the deceased alive on <b>Dec 23</b> , 1959, and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>William D. Rosson M.D. 5304 ANNAPOLIS ROAD BLADENSBURG, MARYLAND.</b>	
ACTUAL SIGNATURE		DATE SIGNED <b>12/25/59</b>	
PHYSICIAN'S NAME (Type) <b>William D. Rosson</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 28, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b> <b>Baltimore</b> <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>	
24a. REC'D BY REGISTRAR <b>Arthur S. Kline</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14371

**Reg. Dist. No.**

14065

## **CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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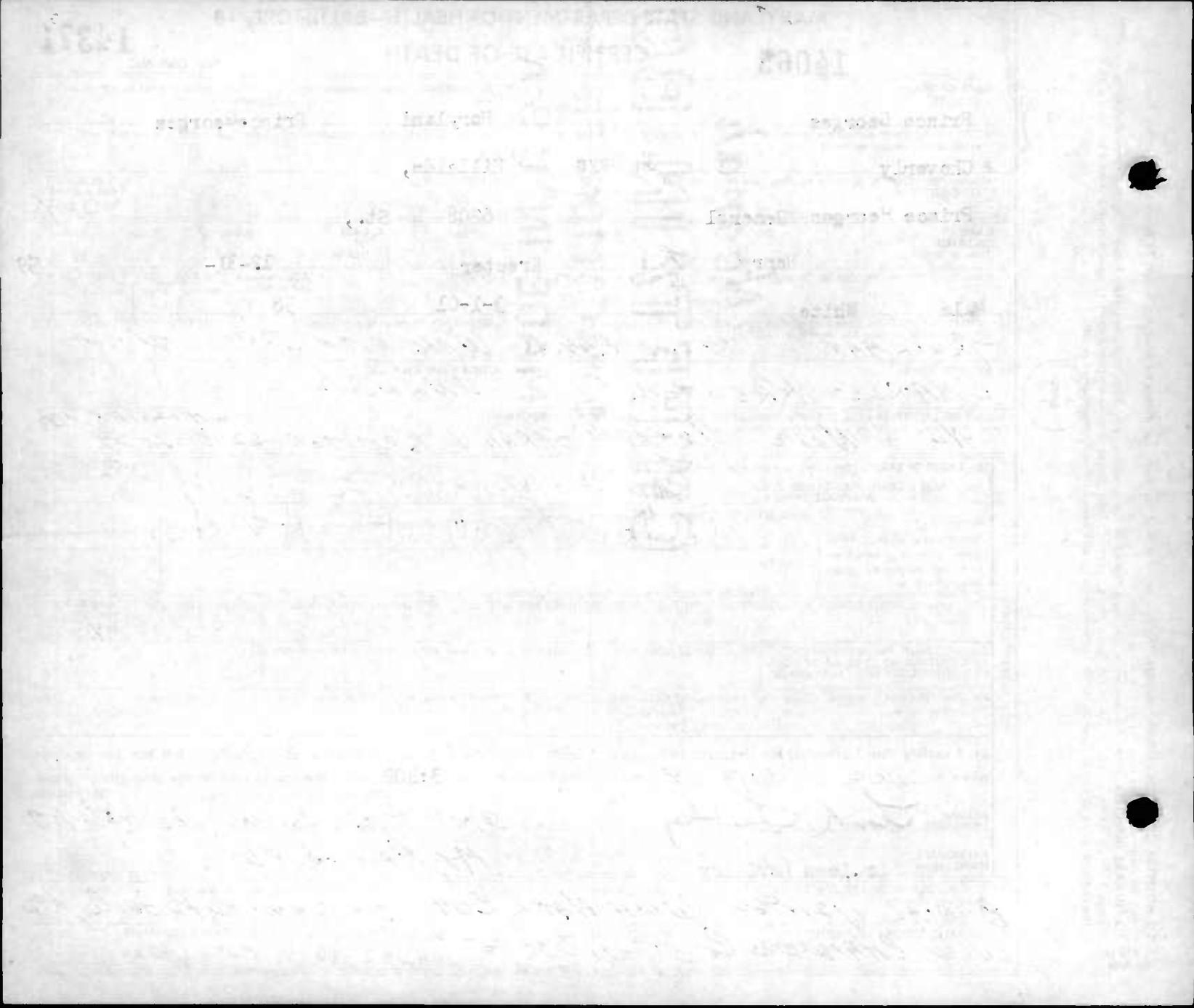
077

1

2 MEDICAL CERTIFICATION

28

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Prince Georges				a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY Prince Georges	
RURAL and give nearest town) Cheverly		34 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		30		d. STREET ADDRESS	
Prince Georges General		Hillside,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
First		Middle		6208 L St.,	
3. NAME OF DECEASED (Type or print)		Last		4. DATE OF DEATH	
Henry J.		Kreuter		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		3-1-01		9. AGE (In years last birthday) 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
TRUCK MAN		RAILWAY EXPRESS		WASHINGTON, D.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
CHARLES KREUTER		UNKNOWN		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Address	
No		UNKNOWN		SARAH L. KREUTER -6208-L-ST. HILLSIDE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)		Bimbo Ponunen - Carter's School At de.			
420.0		DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)			
{		DUE TO			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY		Month	Day	Year	
Hour		a. m.	19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
p. m.					
21. I certify that I attended the deceased from		11-26		1959, to Dec 30 1959 that I last saw the deceased alive on Dec 30 1959, and that death occurred at 3:40 PM, from the causes and on the date stated above.	
ACTUAL SIGNATURE		M.D.		ADDRESS (Street, city or town, state)	
Dr. Leon Levitsky		3408 Rhode Island Av		DATE SIGNED 12/31/59	
PHYSICIAN'S NAME (Type)		Mt. Rainier, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL	
Burial		1/2/1960		WASH NATL CEM.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
W.W. Chambers Co-517-1155 SE		5001 Belair		DATE JAN 7 '60	
24b. REGISTRAR'S SIGNATURE				Arthur S. Kraus	



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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

<b>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</b>												
<b>14066 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>												
Reg. Dist. No. 14043												
<b>1. PLACE OF DEATH</b> a. COUNTY      Prince Georges      MARYLAND						<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) ✓ a. STATE      Maryland      b. COUNTY      1						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			d. STREET ADDRESS 96 Kingston Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> <small>(Type or print)</small>		First Johnnie	Middle Radford	Last Lane	<b>4. DATE OF DEATH</b> December 4, 1959							
<b>5. SEX</b> Male		<b>6. COLOR OR RACE</b> white	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> Dec. 8, 1914		<b>9. AGE</b> (In years <small>last birthday</small> ) 44 yrs.		<b>10. IF UNDER 1 YEAR</b> Months      Days		<b>11. IF UNDER 24 HRS.</b> Hours      Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Electronic inspector			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> U.S.Govt.			<b>11. BIRTHPLACE</b> (State or foreign country) Texas			<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.			
<b>13. FATHER'S NAME</b> CHARLES LANE						<b>14. MOTHER'S MAIDEN NAME</b> ERTA NICTOLS						
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> <small>(Yes, no, or unknown)</small>		<b>16. SOCIAL SECURITY NO.</b> Yes      U.S.N		<b>17. INFORMANT</b> 215-16-6639		Mary Anna Lane; same address as # 2. <small>Address</small>						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]												
<b>PART I. DEATH WAS CAUSED BY:</b> <small>IMMEDIATE CAUSE (a)</small> Acute congestive heart failure      INTERVAL BETWEEN ONSET AND DEATH												
<small>442 X</small> <small>DUE TO</small> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</small> (b)      Cardiovascular renal disease												
<small>DUE TO</small> <small>(c)</small>												
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>												
<b>19. WAS AUTOPSY PERFORMED?</b> <small>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></small>												
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY <small>Hour</small> o. m.      19 p. m.			20d. INJURY OCCURRED <small>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></small>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>												
<b>MEDICAL CERTIFICATION</b>												
ACTUAL SIGNATURE <i>John T. Maloney</i> DATE SIGNED December 4, 1959												
EXAMINER'S NAME (Type) John T. Maloney, M.D.      M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>												
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> Burial		<b>22b. DATE THEREOF</b> 12-8-59		<b>22c. NAME OF CEMETERY OR CREMATORIUM</b> St. Mary's		<b>22d. LOCATION (City, town, or county)</b> Annapolis, Maryland		<small>(State)</small>				
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>John J. Connolly 418 E. Chester Glid.</i>						<b>ADDRESS</b> <i>23</i>		<b>24a. REC'D BY REGISTRAR</b> DEC 8 '59		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Frank</i>		

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14044

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</b>											
<b>CERTIFICATE OF DEATH</b>											
Reg. Dist. No. _____											
<b>1. PLACE OF DEATH</b> a. COUNTY      Prince Georges      MARYLAND						<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE      b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47x-3					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor						d. STREET ADDRESS 5521 Colorado Ave. N.W.					
<b>3. NAME OF DECEASED</b> (Type or print)      Elizabeth S. Leahy						<b>4. DATE OF DEATH</b> Dec. 12, 1959      Month Day Year 19					
<b>5. SEX</b> female		<b>6. COLOR OR RACE</b> white		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> 2/9/89		<b>9. AGE (In years last birthday)</b> 70 yrs.		IF UNDER 1 YEAR      IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Massachusetts			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME David Sullivan						14. MOTHER'S MAIDEN NAME Katherine Cuddihy					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)      If yes, give war or dates of service no			16. SOCIAL SECURITY NO. 226-38-8904			INFORMANT David E. Leahy			Address 6101 16th St. N.W. Washington, D.C.		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)      Cerebral Hemorrhage      INTERVAL BETWEEN ONSET AND DEATH 450.0      18 hrs.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)      An aneurysm Rt. Temporal Artery      5 yrs. (c)      Arteriosclerosis      10 yrs.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none											
20c. TIME OF INJURY      Month, Day, Year Hour o. m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)      (State)					
21. I certify that I attended the deceased from June 1951 to Dec. 12, 1959 that I last saw the deceased alive on Dec. 12, 1959, and that death occurred at 11 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE      Francis T. Coleman M.D. 5315-16th St. N.W. Wash. D.C. DATE SIGNED 12/13/59 PHYSICIAN'S NAME (Type)      Francis T. Coleman											
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/15/59		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Suitland, Md. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington 9, D.C.						ADDRESS (Street, city or town, state) 2901 16th St. N.W.		24a. REC'D BY REGISTRAR DATE DEC 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

71041

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12, 13, 14 Film G254 1-13-60 et

14067

## CERTIFICATE OF DEATH

Reg. Dist. No.

14045

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>22Hr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Beltsville</b>		d. STREET ADDRESS <b>6309 Muirkirk Rd.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Lyle</b>		First	Middle	Last	4. DATE OF DEATH <b>Dec. 6 1959</b>	Month	Day	Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-1-59</b>		9. AGE (In years last birthday) yrs. <b>3</b>	10. IF UNDER 1 YEAR Months <b>3</b> Days <b>6</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Solomon Lesane</b>		14. MOTHER'S MAIDEN NAME <b>Helen Marshall</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>492X</b> DUE TO <b>Keruromonitis R1. &amp; Encephema</b> INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>4713 Fremont St</b>		(County) <b>Baltimore</b> (State) <b>Md.</b>
21. I certify that I attended the deceased from <b>Dec. 6 1959</b> , to <b>Dec. 6 1959</b> , that I last saw the deceased alive on <b>Dec. 6 1959</b> , and that death occurred <b>2:45 P.M.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>W. L. Etienne</i>		ADDRESS (Street, city or town, state) <b>4713 Fremont St</b> DATE SIGNED <b>12/14/59</b>						
PHYSICIAN'S NAME (Type) <b>W. L. Etienne</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-12-59</b>		22b. DATE THEREOF <b>12-12-59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>New Harmony</b>		22d. LOCATION (City, town, or county) <b>389 Rhode Island St</b>		(State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frozier's Funeral Home</i>		ADDRESS <b>389 Rhode Island St</b>		24a. REC'D BY REGISTRAR <b>DEC 14 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>		
2077366XVS								

Birth certificate filed 9/3/59 under  
Lyle Donnel Marshall -

(Mother give different information on  
each admission to the hospital)

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14046

14019

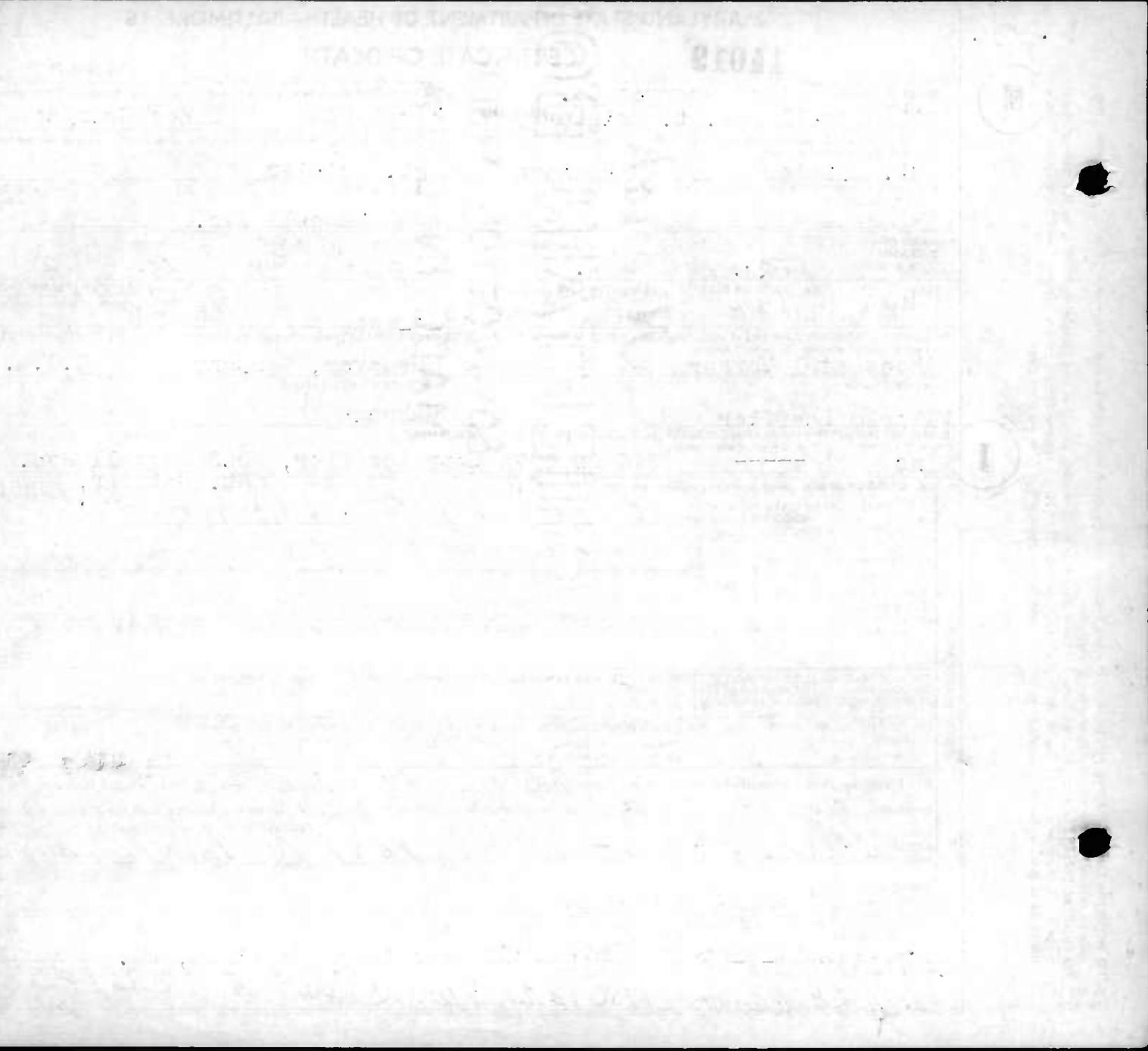
## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY 4303 Russell Ave. Mt. Rainier		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. LENGTH OF STAY IN 1b Unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier	
		d. STREET ADDRESS 1 4303 Russell Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
FRANK		W.	Last
4. DATE OF DEATH		Month	Day
LOEFFLER		Dec.	2.
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Male		White	B. DATE OF BIRTH 17-6-1894
9. AGE (In years lost birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheetmetal Worker	11. BIRTHPLACE (State or foreign country) Hanover, Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wilhelm Loeffler	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 578 09 0272		INFORMANT	Address
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Emmy Loeffler, 4303 Russell Ave. Mt. Rainier, Md.	
18. INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 3, 1959</u> , to <u>Dec. 2, 1959</u> that I last saw the deceased alive on <u>Nov. 14, 1959</u> , and that death occurred at <u>3 a.m.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 20216 St. N.W. Dec. 2, 1959	
ACTUAL SIGNATURE <i>Hugo Einstein</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type) HUGO EINSTEIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12-5-59	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory
22d. LOCATION (City, town, or county) Suitland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Chambers Sons, 1756 P. Ave. N.W. D.C.</i>		24a. REC'D BY REGISTRAR DATE DEC 7 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												Reg. Dist. No. 14047			
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>				Pr <sup>e</sup> ince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>6 Days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Fairmont Heights</b>				d. STREET ADDRESS <b>1105 60th Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Dab<sup>y</sup> Boy</b>				First	Middle	Last	4. DATE OF DEATH <b>Luckett</b>	Month	Day	Year	December	9	19	59	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>December 4, 1959</b>	9. AGE (In years last birthday) yrs. <b>6</b>	IF UNDER 1 YEAR Months <b>6</b>	IF UNDER 24 HRS. Days <b>6</b>	Hours <b>0</b>	Min. <b>0</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>762.5</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>James Nickles</b>				14. MOTHER'S MAIDEN NAME <b>Christine Luckett</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				INFORMANT				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>prematurity</b> DUE TO <b>762.5</b>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>atlectasis</b> DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) <b>6905 Baltimore Ave.</b>		(County) <b>College Park, Md.</b>	(State)
21. I certify that I attended the deceased from <b>Dec. 4, 1959</b> , to <b>Dec. 9, 1959</b> , that I last saw the deceased alive on <b>Dec. 9, 1959</b> , and that death occurred at <b>6:05 PM</b> , from the causes and on the date stated above.												ADDRESS (Street, city or town, state) <b>1260 39</b>			
ACTUAL SIGNATURE <b>Thomas A. Christensen</b> M.D.												DATE SIGNED <b>12/16/59</b>			
PHYSICIAN'S NAME (Type) <b>Dr Thomas A. Christensen, M.D.</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>12/16/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Prince George's General Hospital, Cheverly, Md.</b>				22d. LOCATION (City, town, or county) <b>College Park, Md.</b>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b>				ADDRESS <b>Administrator</b>				24a. REC'D BY REGISTRAR <b>DEC 21 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>			
207/162XVI															

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14069

## CERTIFICATE OF DEATH

Reg. Dist. No.

14048

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
1SM 9/55

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN 1b <b>Laurel General Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Simpsonville</b>		d. STREET ADDRESS <b>13x-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Laurel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Racheal</b>		First	Middle	Last	4. DATE OF DEATH <b>Macgrill</b>	Month <b>December</b>	Doy <b>2</b>	Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/></b>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Jan. 25, 1881</b>	9. AGE (In years lost birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Dorsey Owings</b>			
13. FATHER'S NAME <b>John R. Clarke</b>		14. MOTHER'S MAIDEN NAME <b>Susan O'KELLY</b>		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5705</b> <i>Cardiac Failure, Shock</i>		DUE TO  (b) <i>Hepatinal obstruction, Diabetes</i>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  (c) <i>Hepatinal obstruction, Diabetes</i>		DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 19	Year 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Ellicott City, Md.</b>	20f. (City or town) <b>Ellicott City, Md.</b>	(County) <b>Ellicott City, Md.</b>	(State) <b>Ellicott City, Md.</b>	
21. I certify that I attended the deceased from <b>11-27</b> , 19 <b>59</b> , to <b>12-2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-2</b> , 19 <b>59</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>Ellicott City, Md.</b> DATE SIGNED <b>Arthur J. Kraus</b>									
ACTUAL SIGNATURE <b>Idolo Pierandrei</b> M.D. 305 Prince George Street, Laurel, Maryland									
PHYSICIAN'S NAME (Type) <b>Idolo Pierandrei, M.D. 305 Prince George Street, Laurel, Maryland. 12/3/59</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-4-59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Johns</b>		22d. LOCATION (City, town, or county) <b>Ellicott City, Md.</b>		(State) <b>Ellicott City, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 7 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kraus</b>				

## CERTIFICATE OF DEATH

15002

REMARKS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1410S

## CERTIFICATE OF DEATH

Reg. Dist. No.

14040

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE COUNTY MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE COUNTY</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUITLAND</b>	c. LENGTH OF STAY IN 1b <b>3 Months</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>	d. STREET ADDRESS <b>3134 Parkway Terr. Dr. Apt #6</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <b>JAMES</b>	Middle <b>GARRET</b>	Last <b>MADDEN</b>					
4. DATE OF DEATH <b>December 26 1959</b>	Month Year							
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7 September 1959</b>	9. AGE (In years last birthday) yrs. <b>3 19</b>	IF UNDER 1 YEAR Months <b>3</b>	IF UNDER 24 HRS. Days <b>19</b>	Hours <b>00</b>	Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland Prince George County</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>James D. Madden</b>			14. MOTHER'S MAIDEN NAME <b>Constance W. SCHROEDER</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Father 3134 Parkway Derr Dr. Apt 6</b>		Address <b>Suitland, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Unknown, pending Autopsy Report</b> INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) <b>493 X</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Andrews</b> (State) <b>Md.</b>		
21. I certify that I attended the deceased from <b>26 Dec 1959</b> , to <b>26 Dec 1959</b> , that I last saw the deceased alive on <b>DOA 26 Dec 1959</b> , and that death occurred at <b>0841 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>USAF Hospital Andrews, Andrews Air Force Base Prince George County, Maryland</b> DATE SIGNED <b>26 Dec 59</b>								
ACTUAL SIGNATURE <b>Sanford L. Billet</b> M.D.								
PHYSICIAN'S NAME (Type) <b>SANFORD L. BILLET, Capt USAF MC</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/28/59</b>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>816 N Street, N. E.</b>		22d. LOCATION (City, town, or county) (State) <b>Auburn, New York</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Michael J. Rinaldi</b>		23. ADDRESS <b>Rinaldi Funeral Home Wash. 2, D. C.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

87. DROMITIAS-ΗΤ ΕΛΛΗΝΩΝ ΤΗΜΑΤΑ ΔΙΑΣΤΟΛΗΣ ΟΙΚΑΙΡΩΜΑ

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14109

## CERTIFICATE OF DEATH

Reg. Dist. No.

14050

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE COUNTY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>PRINCE GEORGE COUNTY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Andrews Air Force Base</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X USAF Hospital Andrews, Andrews AFB</b>		d. STREET ADDRESS <b>412 60th Avenue, Capitol Heights</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF Hospital Andrews, Andrews AFB</b>				d. STREET ADDRESS <b>412 60th Avenue, Capitol Heights</b>		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Mary</b>	Middle <b>Elizabeth</b>	Last <b>MALLOY</b>	4. DATE OF DEATH	Month <b>December</b>	Day <b>26</b>	Year <b>19 59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>16 December 1959</b>	9. AGE (In years last birthday) yrs. <b>0</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>10</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John X. Malloy</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Jean HARMON</b>			Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>(Birth Certificate)</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>340.3</b> DUE TO <b>MENINGITIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Premature birth</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>4/16 5/02</b>							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Boston</b>	(County) <b>Massachusetts</b>	(State) <b>Massachusetts</b>	
21. I certify that I attended the deceased from <b>16 Dec</b> , 1959, to <b>26 Dec</b> , 1959, that I last saw the deceased alive on <b>26 Dec</b> , 1959, and that death occurred at <b>0148 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Andrews Air Force Base</b>									
ACTUAL SIGNATURE <i>John A. Moore</i>		M.D.		Andrews Air Force Base		DATE SIGNED <b>26 Dec 59</b>			
PHYSICIAN'S NAME (Type) <b>JOHN A. MOORE, Capt USAF MC</b>				Washington 25, D. C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/28/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) <b>Boston, Massachusetts</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Michael J. Rinaldi</i>		ADDRESS <b>816 H Street, N. E.</b>		24a. REC'D BY REGISTRAR <b>DEC 28 59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>			
VS A1S (4) 15M 9/55									



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**FOR STATE  
HEALTH DEPT.**

14051

Reg. Dist. No.

14110

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville (Rural)</b>		c. LENGTH OF STAY IN 1b <b>Transient</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Tony's Texaco, Junction Route #50 &amp; #301</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>PAUL</b>	Middle <b>NATHANIEL</b>	4. DATE OF DEATH Lost <b>MARSHALL</b> Month <b>December</b> Day <b>7th,</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14th, 1935</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School Bldg.</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>
13. FATHER'S NAME <b>Michael Jerpme Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Elsie Marie Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Michael J. Marshall, Route # 1, Mitchellville, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage &amp; Shock</b> <b>981X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  (b) <b>Gunshot wound of chest</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Type of injury in Part I or Part II of item 18.) <b>His attempted Shot during holdup of gas station</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>12:17 p.m. 12/7/1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Please of death</b>
20f. (City or town) <b>Mitchellville, Pr. GeoCo., Md.</b>		(County) <b>Prince Georges Co.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  <i>James I. Boyd</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>12/7/1959</b>
EXAMINER'S NAME (Type)  <b>James I. Boyd, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)  <b>12-11-59</b>	22b. DATE THEREOF  <b>12-11-59</b>	22c. NAME OF CEMETERY OR CREMATORIUM  <b>Bethel Arlington N.W. Arlington Va</b>	22d. LOCATION (City, town, or County) (State)  <b>Arlington Va</b>
23. FUNERAL DIRECTOR'S SIGNATURE  <b>H. Washington</b>	ADDRESS  <b>467 14 St. NW</b>	24a. REC'D BY REGISTRAR  <b>John S. Thomas</b>	24b. REGISTRAR'S SIGNATURE  <b>John S. Thomas</b>
VS. A15ME 5M. 2/57		DATE DEC 14 '59	

WISCONSIN STATE DEPARTMENT OF HEALTH - JOURNAL  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED PERSON

DEATH DATE

DEATH PLACE

DEATH NUMBER

NAME OF DECEASED PERSON  
MATERIAL TESTED

TESTS FOR

LETHALITY

STRENGTH

TYPE

Fatty acids       Glycerol       Alcohol

Proteins       Lipids       Carbohydrates

Sugars       Amino acids       Fats

Vitamins       Minerals       Enzymes

Hormones       Vitamins       Minerals

Enzymes       Vitamins       Minerals

Hormones       Vitamins       Minerals

Enzymes       Vitamins       Minerals

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

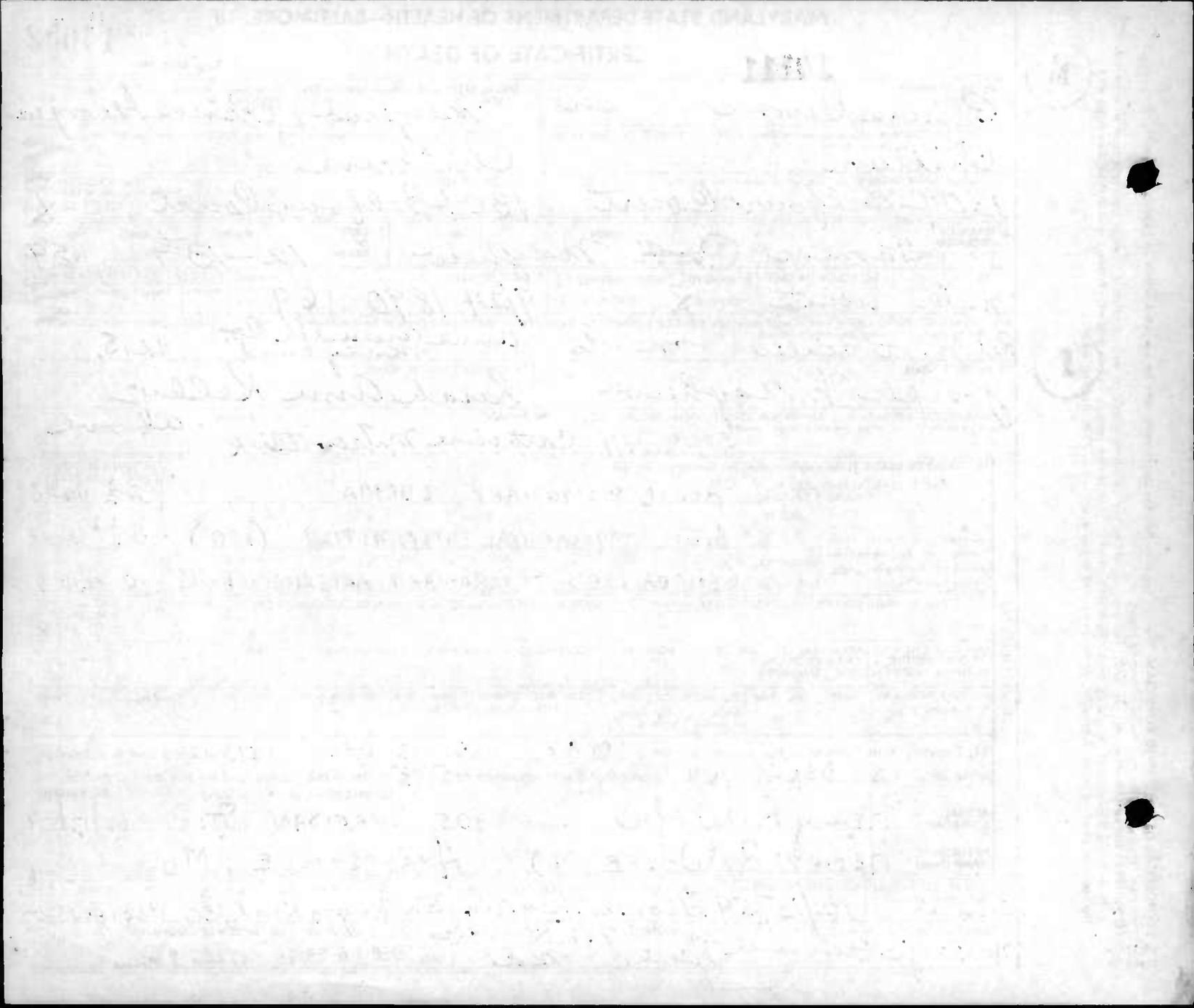
Reg. Dist. No.

14052

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chillum</i>	c. LENGTH OF STAY IN lb <i>Chillum</i>	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chillum</i>	e. b. COUNTY <i>Prince Georges</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1307-Balfour Court</i>	d. STREET ADDRESS <i>1307-Balfour Court</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Thomas P. Mayhew</i>	First <i>Thomas</i>	Middle <i>P.</i>	Last <i>Mayhew</i>
4. DATE OF DEATH <i>12-13<sup>th</sup> 1959</i>	Month <i>Dec.</i>	Day <i>13</i>	Year <i>1959</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/24/1890</i>
9. AGE (In years (last birthday) yrs. <i>69</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Butcher meat dealer</i>	11. KIND OF BUSINESS OR INDUSTRY <i>meats</i>	12. BIRTHPLACE (State or foreign country) <i>Anne Arundel Co., Maryland</i>
13. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	14. FATHER'S NAME <i>Joseph W. Mayhew</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>579-46-3971</i>	INFORMANT <i>Catherine M. Trevittick</i>	Address <i>Above</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> ACUTE PULMONARY EDEMA INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 hours</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>ACUTE MYOCARDIAL INFARCTION (3RD)</i> 2 1/4 hours			
DUE TO (c) <i>GENERALIZED + CORONARY ARTERIOSCLEROSIS</i> 10 YEARS			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>MAY</i> , 19 <i>59</i> , to <i>13 DEC.</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>13 DEC.</i> , 19 <i>59</i> , and that death occurred at <i>5:58 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry R. Wolfe</i>		ADDRESS (Street, city or town, state) <i>905 SHERIDAN ST. HYATTSVILLE, MD.</i>	
PHYSICIAN'S NAME (Type) <i>HENRY R. WOLFE M.D.</i>		DATE SIGNED <i>12/13/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/15/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>George Washington Riggs Road, Prince Georges Co.</i>		22d. LOCATION (City, town, or county) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home, Md.</i>		ADDRESS <i>Mt. Rainier</i> REC'D BY REGISTRAR DATE <i>DEC 16 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14053

## CERTIFICATE OF DEATH

Reg. Dist. No.

14112

1. PLACE OF DEATH a. COUNTY <i>Prince George MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>PR. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CAMP SPRINGS</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X CAMP SPRINGS</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5250-Auth Rd.</i>		d. STREET ADDRESS <i>5250-Auth Rd</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>MARTHA</i>	Middle <i>C. S.</i>	Last <i>MAY Hugh</i>
4. DATE OF DEATH	Month <i>Dec.</i>	Day <i>13</i>	Year <i>1959</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-28-1874</i>
9. AGE (In years lost birthday) <i>85 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) <i>Indiana</i>
13. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	14. MOTHER'S MAIDEN NAME <i>Mary Jane McKay</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	INFORMANT <i>Alice M. Dibrell</i>	Address <i>5250-Auth Rd</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute congestive heart failure</i> 2 days DUE TO <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Arteriosclerosis heart disease</i> 5 years DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis, Emphysema</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19) <i>Emphysema</i>	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 1, 1949</i> to <i>12-13, 1959</i> that I last saw the deceased alive on <i>12-13, 1959</i> , and that death occurred at <i>11 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>DAVID S. GORDON</i>	ADDRESS (Street, city or town, state) <i>5731 22nd Avenue SE</i>		
PHYSICIAN'S NAME (Type) <i>DAVID S. GORDON, MD</i>	DATE SIGNED <i>12-13-59</i>		
22a. BURIAL, CREMATION, REINTERMENT (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>12-14-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>	22d. LOCATION (City, town, or county) <i>Sutton</i> (State) <i>MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Summons Bros. Funeral Home</i>		ADDRESS <i>1661-Good Hope St.</i>	24a. REC'D. BY REGISTRAR <i>DEC 16 1959</i>
		DATE <i>WASL 202C</i>	24b. REGISTRAR'S SIGNATURE <i>David S. Gordon</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECORDED - INDEXED - COPIED - FILED

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14054

## CERTIFICATE OF DEATH

Reg. Dist. No.

14113

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Prince Geo's</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brandywine</i> c. LENGTH OF STAY IN 1b <i>Life</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>--</i>				<b>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</b> a. STATE <i>Md.</i> b. COUNTY <i>Pr. Geo.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Brandywine, Md.</i> d. STREET ADDRESS <i>Route 3, Box 50</i>			
<b>3. NAME OF DECEASED</b> First <i>Roderic</i> Middle <i>Paul</i> Last <i>meinhardt</i> <b>4. DATE OF DEATH</b> <i>December 2 1959</i>				<b>Month</b> <b>Day</b> <b>Year</b>			
<b>5. SEX</b> <i>Male</i>		<b>6. COLOR OR RACE</b> <i>white</i>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <i>April 21, 1959</i>		<b>9. AGE (In years lost birthday)</b> yrs. <i>7</i> <b>IF UNDER 1 YEAR</b> Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i> <b>IF UNDER 24 HRS.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>--</i>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>--</i>			
<b>11. BIRTHPLACE</b> (State or foreign country) <i>Md</i>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>			
<b>13. FATHER'S NAME</b> <i>Theodore Meinhardt</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Marilyn Ruth Ely</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <i>No</i>				<b>16. SOCIAL SECURITY NO.</b> <i>—</i>			
<b>17. INFORMANT</b> <i>Theodore Meinhardt-Same as above.</i>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>none</i>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]							
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <i>Sepsis</i> <b>Suspecter</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b> (b) <i>Acute Tracheo-Bronchitis</i> <b>DUE TO</b> (c) <i>Infection</i>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <i>—</i>		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <i>12-2</i> , 19 <i>57</i> <b>to</b> <i>12-2</i> , 19 <i>57</i> , <b>that I last saw the deceased alive on</b> <i>12-2</i> , 19 <i>59</i> , <b>and that death occurred at</b> <i>5:35 AM</i> , <b>from the causes and on the date stated above.</b> <b>ADDRESS</b> (Street, city or town, state) <i>Brandywine, Md.</i> <b>DATE SIGNED</b> <i>Dec. 2, 59</i>							
<b>ACTUAL SIGNATURE</b> <i>Richard H. Dobson</i> <b>M.D.</b>							
<b>POLICE INFORMATION</b> <b>PHYSICIAN'S NAME (Type)</b> <i>Richard H. Dobson</i> <b>BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i> <b>DATE THEREOF</b> <i>12/4/59</i> <b>NAME OF CEMETERY OR CREMATORIUM</b> <i>Cheltenham Cemetery</i> <b>LOCATION (City, town, or county)</b> <i>Cheltenham, Md.</i> <b>(State)</b>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Ritchie Bros. Funeral Home-Marlboro, Md.</i> <b>ADDRESS</b> <i>Upper</i> <b>REC'D BY REGISTRAR</b> <i>DEC 7 '59</i> <b>REGISTRAR'S SIGNATURE</b> <i>Arthur S. Times</i> <b>DATE</b>							

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4  
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The hospital or attending physician may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

St Mary's  
" Charles

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14070

## CERTIFICATE OF DEATH

Reg. Dist. No.

14055

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Md - b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb 50 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital		e. STREET ADDRESS 23 Greenbelt Box 144	
3. NAME OF DECEASED (Type or print) George		First W.	Middle Miles
4. DATE OF DEATH December 31 1959	Month	Day	Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17th, 1895
9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Public Schools	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Walter Miles		14. MOTHER'S MAIDEN NAME Minnie Weiskettel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. 578-20-0996HA	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I(o) Hypertensive Cardiovascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-16, 1959, to 12-30, 1959, that I last saw the deceased alive on 12-30, 1959, and that death occurred at 5:15 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE D.R. Purdie M.D. ADDRESS (Street, city or town, state) 4408 Queensbury Road, Riverdale, Md. DATE SIGNED 12/31/59			
PHYSICIAN'S NAME (Type) D.R. Purdie, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1/2/1960 22c. NAME OF CEMETERY OR CREMATORIUM Washington Nat'l Cem. 22d. LOCATION (City, town, or county) (State) Suitland, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.H. Chomber & Son, Riverdale Md.		ADDRESS 24a. REC'D BY REGISTRAR DATE JAN 4 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Turner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG254 1-4-60 et

14056

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Md</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>4 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5304 Taylor Rd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James C. Miller</b>		First <b>James</b>	Middle <b>C.</b>
4. DATE OF DEATH <b>Dec 18, 1959</b>	Month <b>Dec</b>	Day <b>18</b>	Year <b>1959</b>
S. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 20, 1892</b>
9. AGE (In years lost birthday) <b>67 88 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b>	11. IF UNDER 24 HRS. Hours <b>88</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington Gas Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Marshall Miller</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. INFORMANT <b>Julia M White Hyattsville Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>33IX</b>		INTERVAL BETWEEN ONSET AND DEATH <i>Cerebral hemorrhage (Cerebral Hemorrhage)</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO <i>Generalized arteriosclerosis.</i>			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-27</b> , 19 <b>59</b> , to <b>12-18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-18</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. Deitz</i>		ADDRESS (Street, city or town, state) <b>4314- GALLATIN ST.</b>	
PHYSICIAN'S NAME (Type) <b>AARON DEITZ, M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 22, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Ft Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14057

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>45 Min.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>W.</b>	Last <b>MILLER</b>		
4. DATE OF DEATH <b>December 26 1959</b>	Month	Day	Year		
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>11-18-89</b>		
8. AGE (In years last birthday) <b>70 yrs.</b>		9. IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Southern Dairies</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
13. FATHER'S NAME <b>Marshall M. Miller</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Taylor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or date of service) <b>no 578 10 2659</b>	INFORMANT <b>Mrs Faith Miller</b>	Address <b>Riverdale, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Acute coronary thrombosis</b> <b>Arteriosclerotic cardiovascular disease</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>2 hr.</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>12-7 1953</b> to <b>12-26 1955</b> that I last saw the deceased alive on <b>12-26 1959</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Zelzah Lane</b>	DATE SIGNED <b>12-26-59</b>
ACTUAL SIGNATURE <i>R.D.Bauer M.D.</i>	PHYSICIAN'S NAME (Type) <b>R.D. BAUER, M.D.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec 30, 1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) <b>Suitland Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>	ADDRESS <b>Hyattsville, Md.</b>	24a. REC'D BY REGISTRAR <b>DEC 31 '59</b>	24b. REGISTRAR'S SIGNATURE <i>Albert S. Krause</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
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 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item 13 Film G254 1-4-60 et											
14073 CERTIFICATE OF DEATH											
Reg. Dist. No. 14058											
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 10 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi			d. STREET ADDRESS Adelphi Rd. & Windon Ave		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION Prince George General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First George William Middle Montgomery Last						4. DATE OF DEATH Month Dec Day 18 Year 59					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 18 1901		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Anna Robey					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO.		INFORMANT Lelia wife		Address as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 452X (b) Ruptured aneurysm of left common iliac artery (c) Arteriosclerosis											
INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 12/17, 1959, to 12/18, 1959, that I last saw the deceased alive on 12/18/59, 1959, and that death occurred at 4:05 AM, from the causes and on the date stated above.											
ADDRESS (Street, city or town, state)											
DATE SIGNED 12/18/59											
ACTUAL SIGNATURE <i>Wm A Holbrook</i> COUNTERSIGNED: John J. Murray, Deputy Medical Examiner PHYSICIAN'S NAME (Type) William A. Holbrook M.D. College Park, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)			
Burial		12/21/59		George Wash. Cemetery		Prince George		Md.			
23. FUNERAL DIRECTOR'S SIGNATURE DEAL FUNERAL HOME 4812 Ga Ave NW						ADDRESS 14073					
						24a. REC'D BY REGISTRAR DEC 28 '59		24b. REGISTRAR'S SIGNATURE <i>C. E. K.</i>			

MADE BY SEA 917-13

EX-01

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ONE HUNDRED FIFTY

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

14059

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Prince Georges MARYLAND		a. STATE Maryland	b. COUNTY Pr. Geo.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First George	Middle Winfield	Last Morgan, Sr.
4. DATE OF DEATH	Month December	Day 14,	Year 19 59
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5-28-1901
9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Advisor		10b. KIND OF BUSINESS OR INDUSTRY Library of Congress Wash., D.C.	
10c. BIRTHPLACE (State or foreign country) U.S.A.		11. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas W. Morgan		14. MOTHER'S MAIDEN NAME Laura E. Otto	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 17. INFORMANT George W. Morgan; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> INTERVAL BETWEEN ONSET AND DEATH			
442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE	John T. Maloney		
EXAMINER'S NAME (Type)	John T. Maloney, M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/59	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery
22d. LOCATION (City, town, or county) Suitland Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	24a. REC'D BY REGISTRAR DATE DEC 21 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Knaud

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
14075 CERTIFICATE OF DEATH

Reg. Dist. No.

14060

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREE		c. LENGTH OF STAY IN 1b adm. June 6 - 59	
d. NAME OF HOSPITAL (If not in hospital, give street address) LAUREE SANITARIUM		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	
3. NAME OF DECEASED (Type or print) BRIDGET GOLWAY MURPHY		d. STREET ADDRESS 4890 BATTERY PANE Apt 214	
4. DATE OF DEATH Dec. 3 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 - 5 - 1875	
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard - GOLWAY		14. MOTHER'S MAIDEN NAME MARGARET GOLWAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 126-07-3937	
17. INFORMANT Hosp. Records LAUREE SANITARIUM		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I.—DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes  GARDIAC FIBRILLATION  arteriosclerotic heart disease Many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile dementia (arteriosclerotic)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6 - 1959 to Dec. 3 - 1959, that I last saw the deceased alive on Dec. 3 - 1959, and that death occurred at 5:15 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Erika P. Kraemer M.D. ADDRESS (Street, city or town, state) LAUREE SANITARIUM DATE SIGNED 12-3-59			
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Trans.Bur.		22b. DATE THEREOF 12-5-59	
22c. NAME OF CEMETERY OR CREMATORIAL St. Joseph Cemetery		22d. LOCATION (City, town, or county) Cayoga County, New York (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DEC 7 '59	
		24b. REGISTRAR'S SIGNATURE John E. Kraemer	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14076

## CERTIFICATE OF DEATH

Reg. Dist. No.

14061

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Henry</b>	Middle <b>M</b>	Last <b>Nau Sr.</b>	
4. DATE OF DEATH	Month <b>Dec.</b>	Day <b>23</b>	Year <b>1959</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 June 1897</b>	
9. AGE (In years last birthday) yrs. <b>62</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Naval Gun Factory</b>	11. BIRTHPLACE (State or foreign country) <b>Chicago Illinois</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	13. FATHER'S NAME <b>Henry Nau</b>			
14. MOTHER'S MAIDEN NAME <b>Welhelmina Krause</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			
16. SOCIAL SECURITY NO. <b>none</b>	INFORMANT <b>Ellen Esther Nau</b>	Address <b>Hyattsville Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Pulmonary embolus</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Saddle Embolus aorta</b> <b>48 hrs</b>				
(c) DUE TO <b>Profound infection</b> <b>5 days</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hemorrhaging 12-18-59. Benign prostatic hypertrophy</b>				
20d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-28</b> , 19 <b>55</b> , to <b>12-23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-22-59</b> , 19 <b>59</b> , and that death occurred at <b>3:00 AM</b> , from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>John P. Clum</i>	M.D.	ADDRESS (Street, city or town, state) <b>Hyattsville Md.</b>	DATE SIGNED <b>12-23-59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Clum M.D.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/26/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>George Washington Cemetery</b>	22d. LOCATION (City, town, or county) <b>Hyattsville Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>	ADDRESS <b>Hyattsville Md.</b>	24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thruell</b>	

27081

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

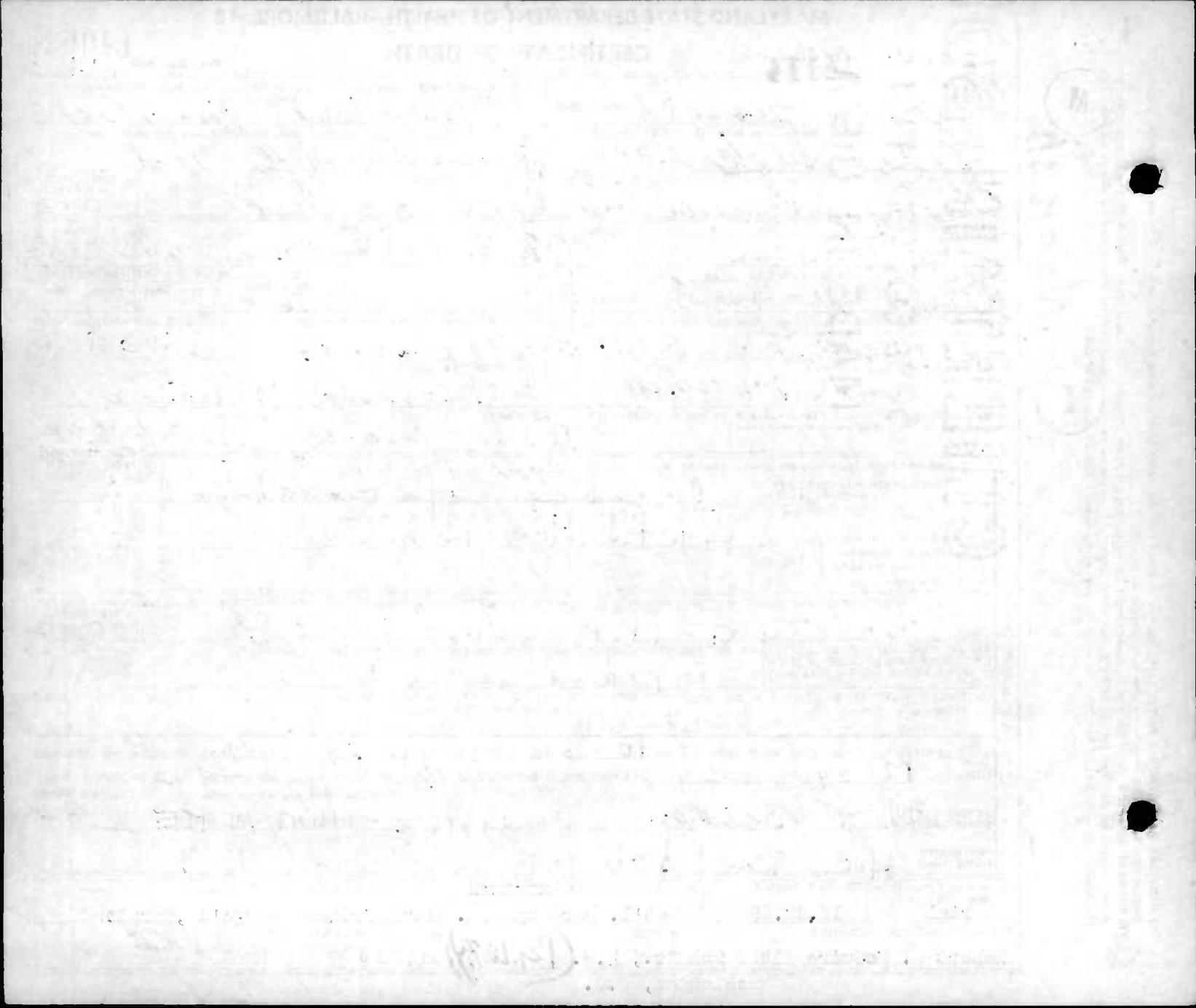
## CERTIFICATE OF DEATH

Reg. Dist. No.

14062

(Laura Nichols.)

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
Prince Georges MARYLAND		Maryland Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Cedar Heights 2 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 904-68 FOR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount Hts., Md.	
Froom's Rest Home ave		f. STREET ADDRESS 806-58-Ave	
3. NAME OF DECEASED (Type or print)		g. DATE OF DEATH Dec. 24 1959	
First Laura		Middle	Last Michaels
4. SEX Female		5. COLOR OR RACE African	
6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spouse wife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aliah Mitchell		14. MOTHER'S MAIDEN NAME Lucinda Mitchell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. If yes, give war or dates of service	
INFORMANT		Address Robert Nichols Jr., 2228-16-Bt NE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO with RT. Hemiplegia ARTIC Riosclerosis			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 9049 Fracture RT. HIP		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 17 fractured in fall.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-31, 1959, to 12-24, 1959, that I last saw the deceased alive on 12-24-1959, and that death occurred at 11:50 PM, from the causes and on the date stated above. ACTUAL SIGNATURE H. C. Beldon		ADDRESS (Street, city or town, state) M.D. 11123 - HUNTER PL N.E. DC 12-24-59	
PHYSICIAN'S NAME (Type) H. C. Beldon MD		DATE SIGNED 12-24-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-29-59	
22c. NAME OF CEMETERY Nat'l. Harmony Mem. Park		22d. LOCATION (City, town, or county) Prince George's, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire		ADDRESS (Per. 10.78) DATE DEC 28 '59	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Dunn	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14063

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>42 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b>		33	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				d. STREET ADDRESS <b>3505 Upshur St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Minnie</b>	Middle	Last <b>Nutall</b>	4. DATE OF DEATH	Month <b>12-</b>	Day <b>8</b>	Year <b>1959</b>
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-5-78</b>	9. AGE (In years last birthday) <b>81 yrs.</b>	IF UNDER 1 YEAR Months <b>81</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Casper Sauter</b>		14. MOTHER'S MAIDEN NAME <b>Annie Sauter</b>		Address <b>Hospital Records</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		INFORMANT		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism with Infarction</b> DUE TO <b>Thrombosis of rt. Iliac Vein</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>450.1</b> (b) <b>Amputation of Legs</b> DUE TO <b>Gangrene of legs secondary to Arteriosclerosis</b> (c) <b>Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <b>Leon L. Gallin</b>		M.D. 7206 Colesville Rd				<b>12/19/59</b>	
PHYSICIAN'S NAME (Type) <b>LEON. L. GALLIN M.D.</b>		West Hyattsville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/11/59</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Mr. Elmer</b>		22d. LOCATION (City, town, or county) <b>Wash. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Timothy Hanlon - 3831 - Gaithersburg, D.C.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>DEC 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11 BROMIDE - 11000 NO. 11000 STATE OF CALIFORNIA

PLATE NO. 20 STANISLAUS

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**CERTIFICATE OF DEATH**

Reg. Dist. No. 14064

14078		CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>21 Da.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>16 Mt. Rainier</b>		d. STREET ADDRESS <b>3300 Chauncy Pl.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>											
3. NAME OF DECEASED (Type or print) <b>Raymond</b>		First	Middle	Last	4. DATE OF DEATH <b>T. O'Connell</b>	Month	Day	Year			
S. SEX <b>Male</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>6-23-1897</b>	9. AGE (In years last birthday) <b>62 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Yard man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>American Oil</b>		11. BIRTHPLACE (State or foreign country) <b>West D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Fredrick H. O'Connell</b>		14. MOTHER'S MAIDEN NAME <b>Agnes V. Dant</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>578-01-733</b>		INFORMANT <b>Evelyn B. O'Connell Wife</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163X</b> DUE TO <b>Bronchopneumonia</b> INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the lung.</b> (c) <b>Boney metastases gen.</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Cottage City, Md.</b>		(County)		(State)	
21. I certify that I attended the deceased from <b>Oct. 1, 1959</b> , to <b>Dec. 24, 1959</b> , that I last saw the deceased alive on <b>12-24, 1959</b> , and that death occurred at <b>97 M</b> from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>George Hageage</b> M.D. 3217-38 FL GEE DATE SIGNED <b>12-25-59</b>											
PHYSICIAN'S NAME (Type) <b>Dr. Geo Hageage M.D.</b>		ADDRESS <b>1317 1/2 N. Glebe</b> REC'D BY REGISTRAR									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-28-1959</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Congressional</b>		22d. LOCATION (City, town, or county) <b>Washington, D.C.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gordon Mattingly</b>		ADDRESS <b>1317 1/2 N. Glebe</b>		REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trahan</b>		DATE <b>DEC 28 '59</b>			
VS A1S (4) 15M 9/58											

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14016

## CERTIFICATE OF DEATH

Reg. Dist. No.

14965

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WASH. DC - DISTRICT OF COLUMBIA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>1 yr 3 mos</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR - 4922 LASALLE RD.</b>		d. STREET ADDRESS <b>3600 CONN. AVE. N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EDWARD</b>		First <b>E</b>	Middle <b>DWARD</b>
Last <b>O'CONNOR</b>		4. DATE OF DEATH <b>December 11 1959</b>	Month Day Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 16, 1876</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FIRE CHIEF</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>DRAINSVILLE VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>THOMAS O'CONNOR</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN KENNEDY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>no</b>	INFORMANT <b>SISTER Agnes PATRICIA - CARROLL MANOR</b>
17. MEDICAL CERTIFICATION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>constrictive heart failure</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 da</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Myocardial infarct</b> <b>10 da</b>			
(c) DUE TO <b>Coronary thrombosis</b> <b>10+ da</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6/22 1959</b> to <b>12/11 1959</b> , that I last saw the deceased alive on <b>12/10 1959</b> , and that death occurred at <b>10:30 AM</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>4523 Harvard St. Washington, D.C.</b> DATE SIGNED <b>12/14/59</b>	
ACTUAL SIGNATURE <b>Richard P. Delaney M.D.</b>		PHYSICIAN'S NAME (Type) <b>Richard P. Delaney</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/14/59</b>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Ft. Lincoln</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. Washington, D. C.</b>		22d. LOCATION (City, town, or county) <b>Prince Georges Co., Md.</b>	24a. REC'D BY REGISTRAR <b>Arthur S. Trahan</b>
		24b. REGISTRAR'S SIGNATURE	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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14115

## CERTIFICATE OF DEATH

Reg. Dist. No.

14066

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park Hgts		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park Hgts				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 4510 Temple Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Fred	Middle V	Last Ousley	4. DATE OF DEATH December 17 1959	Month Dec	Day 17	Year 1959
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1909	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Naval Ordnance		11. BIRTHPLACE (State or foreign country) Tenn		12. CITIZEN OF WHAT COUNTRY? U. S. A		
13. FATHER'S NAME Esco E. Ousley			14. MOTHER'S MAIDEN NAME Maria Warwick					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		INFORMANT Edith M. Ousley	Address 4510 Temple Lane		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE HEART DISEASE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I attended the deceased from <b>September 1959</b> , to <b>DECEMBER 17 1959</b> , that I last saw the deceased alive on <b>12/17 1959</b> , and that death occurred at <b>6 A.M.</b> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>ACTUAL SIGNATURE</b> <i>N. Bruno Kollega</i> M.D. <b>4233 St. Barnabas Rd. - SE Washington 21-D</b>								
22a. BURIAL, CREMATION, REMOVAL—Specify Burial		22b. DATE THEREOF 12/21/59		22c. NAME OF CEMETERY OR CREMATORIUM Brookwalter Cem.		22d. LOCATION (City, town, or county) (State) Inskip Tenn.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Tee Funeral Home - Wash. D.C.</i>		ADDRESS <i>14115</i>		24a. REC'D BY REGISTRAR DATE DEC 23 '59		24b. REGISTRAR'S SIGNATURE <i>John S. Kraus</i>		

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												Reg. Dist. No. 14967			
14116 CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 23 DC 10 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 23 DC											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4404 Porter Ave SE				d. STREET ADDRESS 4404 Porter Ave SE											
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED First Janie Ann Payne Middle				4. DATE OF DEATH Month 12 - Day 11 - Year 1959											
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 21-1881		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY at home Retired				11. BIRTHPLACE (State or foreign country) Maryland							
12. CITIZEN OF WHAT COUNTRY? U.S.															
13. FATHER'S NAME Sylvester Gant				14. MOTHER'S MAIDEN NAME Janie —— unknown											
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown)				16. SOCIAL SECURITY NO. none				17. INFORMANT Janie Teresa Payne Washington 23 DC				Address 4404 Porter Ave Washington 23 DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Coma DUE TO 260x												3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus DUE TO — (c) —												5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Totally blind and General Arteriosclerosis												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Duration unknown — natural causes											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none				(County)		(State)	
21. I certify that I attended the deceased from June 1, 1958 to Dec 11, 1959, that I last saw the deceased alive on Dec 10, 1959, and that death occurred at 5:30 AM, from the causes and on the date stated above.												ADDRESS (Street, city or town, state) 5440 Silver Hill Rd SE		DATE SIGNED	
ACTUAL SIGNATURE PAUL C VAN Natta				M.D.											
PHYSICIAN'S NAME (Type) PAUL C VAN Natta				WASHINGTON 28 DC											
22a. BURIAL/CREMATION, REMOVAL (Specify) 12-15-59				22b. DATE THEREOF 12-15-59				22c. NAME OF CEMETERY, OR CREMATORIAL Lincoln Mem.				22d. LOCATION (City, town, or county) Suitland Rd Md			
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington 467 N St NW				ADDRESS								24a. REC'D BY REGISTRAR DATE DEC 16 '59			
												24b. REGISTRAR'S SIGNATURE Orlene S. Kline			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14007 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14068

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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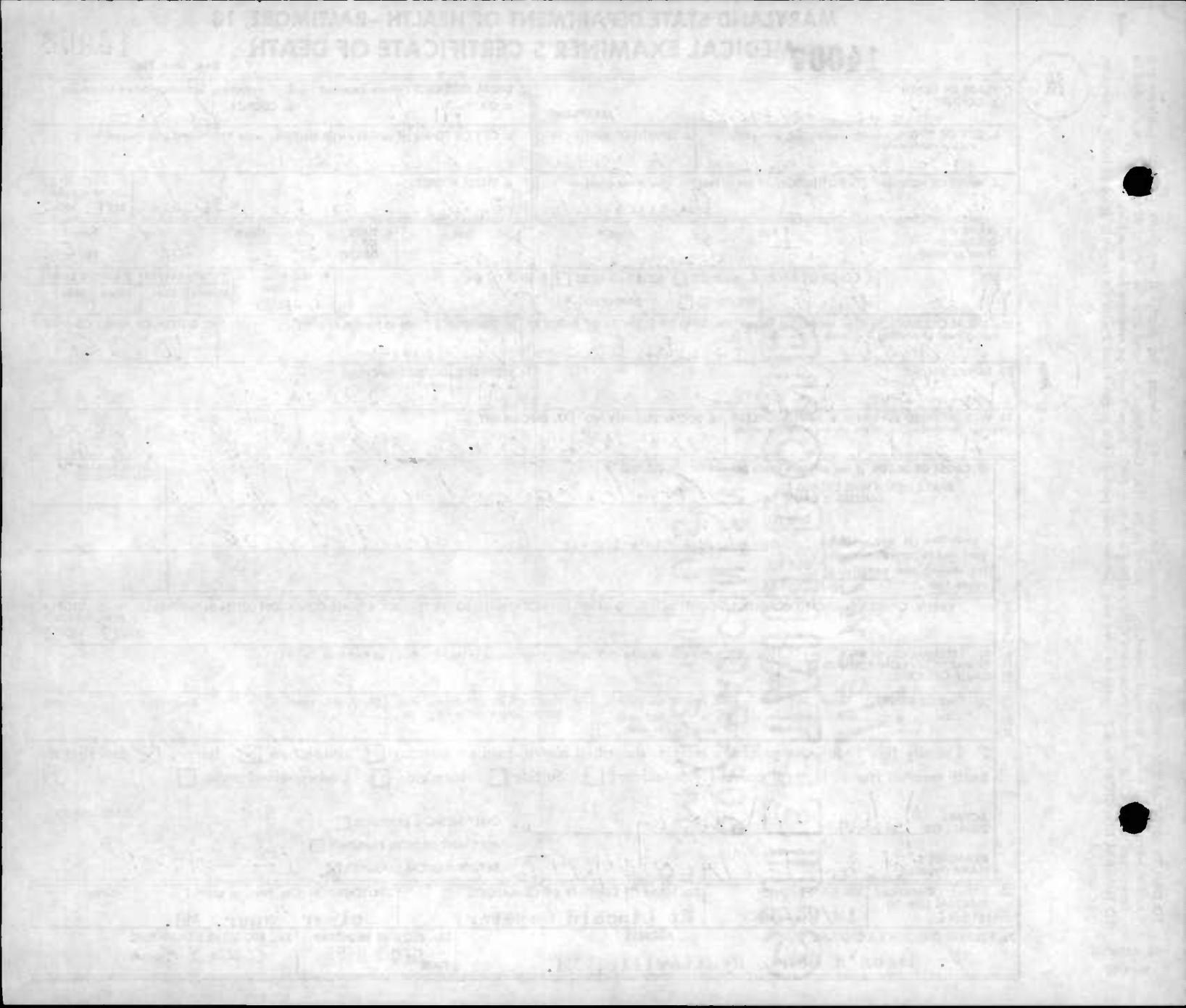
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
<i>Prince George</i>		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>College Park 1 1/2 mo.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>14 College Park.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>9642-Baltimore Boulevard</i>		d. STREET ADDRESS <i>19642-Baltimore Boule-</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Loretta Devere Payne</i>			
Last		4. DATE OF DEATH	Month Day Year
		<i>Dec 24</i>	<i>1959</i>
5. SEX	6. COLOR OF RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-5-10</i>
<i>Male</i>	<i>white</i>		9. AGE (in years last birthday) <i>49 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Carpenter</i>		<i>Construction</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Virginia</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Clinton Payne</i>		<i>Mittie Bailey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
<i>No</i>		<i>577-14-3332 Constance Pector</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address <i>4571 Riverdale Rd., Riverdale, Md.</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)		INTERVAL BETWEEN ONSET AND DEATH	
<i>442X</i>		<i>Acute congestive heart failure</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.		<i>Cardiovascular renal disease</i>	
(b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John T. MALONEY, M.D.</i>		DATE SIGNED <i>12-24-59.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/26/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Ft Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) <i>Colmar Manor, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>DEC 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	



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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

14069

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Alexis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Alexis</i>	
d. LENGTH OF STAY IN 1b <i>6 years</i>		d. STREET ADDRESS <i>8560 River View Road</i>	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>8560 River View Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Gladys</i>	Middle <i>Lorraine</i>	Last <i>Peters</i>
4. DATE OF DEATH	Month <i>Dec</i>	Day <i>6</i>	Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 27, 1910</i>
9. AGE (In years last birthday) <i>49 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clark</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>merchandise</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>US 50</i>
13. FATHER'S NAME <i>Henry Philip Gates</i>	14. MOTHER'S MAIDEN NAME <i>Emma Brockner</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>579-20-1400</i>
17. INFORMANT <i>Elizabeth Hutchinson Nelson</i>		Address <i>8550 Parklawn</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442 X</i> DUE TO <i>Acute congestive heart failure</i> Conditions, if any, which goe rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Cardiovascular renal disease</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  20f. (City or town)  (County)  (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type)  <i>James I. Boyd</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED  <i>12-6-59</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec 9-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Johns</i>	22d. LOCATION (City, town, or county)  (State) <i>Broad Creek End</i>
23. FUNERAL DIRECTOR'S SIGNATURE  <i>Simpson Bros</i>	ADDRESS  <i>1661 94th Hope Rd E</i>	24a. REC'D BY REGISTRAR  <i>DEC 8 '59</i>	24b. REGISTRAR'S SIGNATURE  <i>Arthur S. Traas</i>

六

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14079

## CERTIFICATE OF DEATH

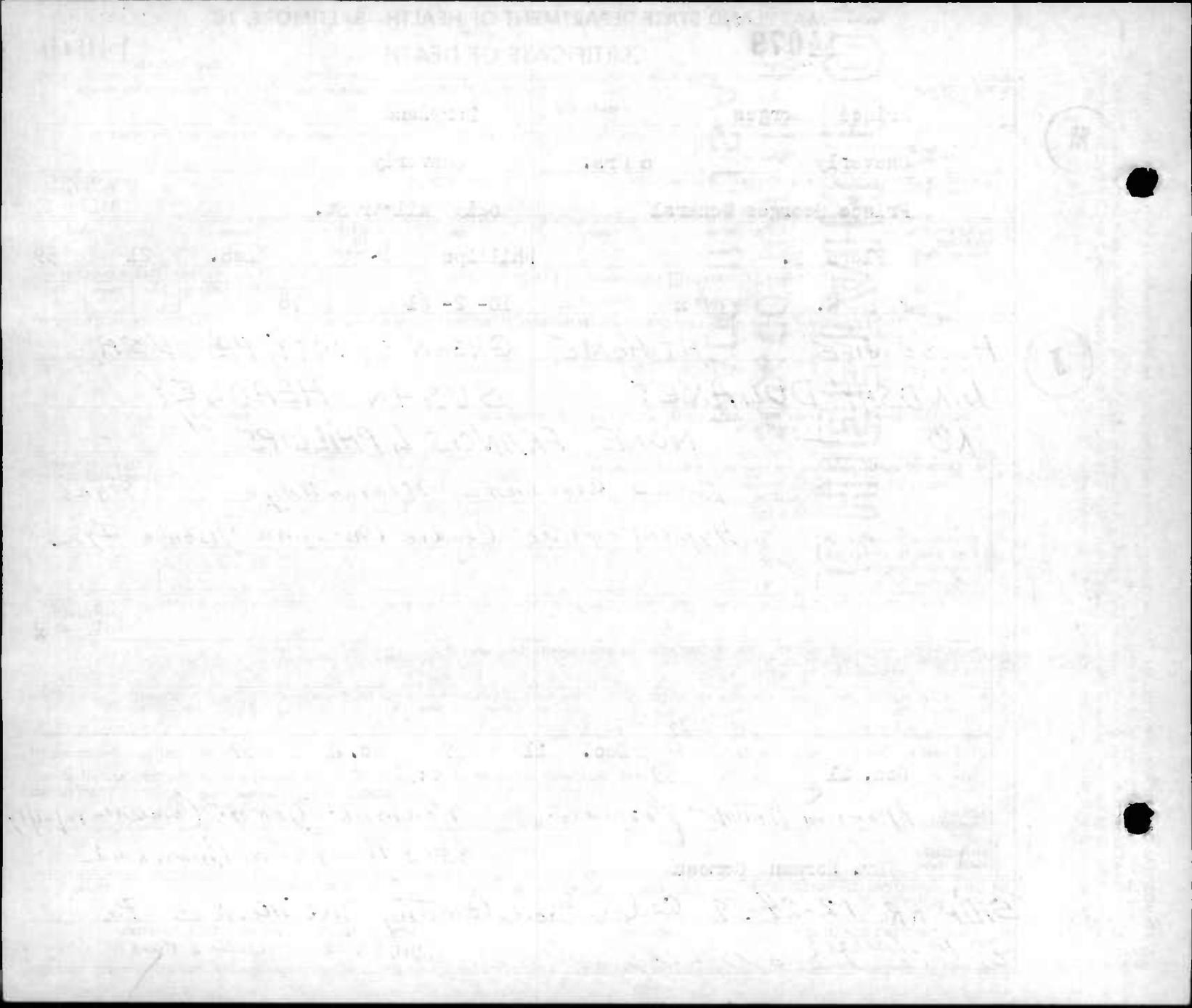
Reg. Dist. No.

14070

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>6 Hrs.</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Flora</b>	Middle <b>B.</b>	Last <b>Phillips</b>			
4. DATE OF DEATH	Month <b>Dec.</b>	Day <b>21</b>	Year <b>19 59</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-2-81</b>			
9. AGE (In years last birthday) <b>78 yrs.</b>	10. IF UNDER 1 YEAR Months <b>71</b>	11. IF UNDER 24 HRS. Days <b>Hours</b>	12. IF UNDER 24 HRS. Hours <b>Min.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (State or foreign country) <b>GREEN COUNTY, PA.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>LINDSAY DULANEY</b>	14. MOTHER'S MAIDEN NAME <b>SUSAN HEADLEY</b>	Address <b>71</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	INFORMANT <b>FRANCIS L. PHILLIPS</b>	17. INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Intra Cerebral Hemorrhage</b>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Hypertensive Cardio Vascular Disease</b> Z yrs (c) <b></b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) <b></b>	(County) <b></b>	(State) <b></b>
21. I certify that I attended the deceased from <b>Dec. 21, 19 59</b> to <b>Dec. 21, 19 59</b> , that I last saw the deceased alive on <b>Dec. 21, 19 59</b> and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.						
ACTUAL SIGNATURE <b>Norman Comeau</b> M.D.				ADDRESS (Street, city or town, state) <b>3503 Penny St Mt Rainier Md</b>		
DATE SIGNED <b>12/21/59</b>						
PHYSICIAN'S NAME (Type) <b>Dr. Norman Comeau</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>SHIP RR.</b> 22b. DATE THEREOF <b>12-24-59</b> 22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Grove Cemetery</b> 22d. LOCATION (City, town, or county) <b>Mt Morris Pa.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. M. Marcell</b>		ADDRESS <b>7111 Chambers St 1400 Chapin St N.W.</b>		24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of the death. The physician or attending physician may be retained.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
1SM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14118

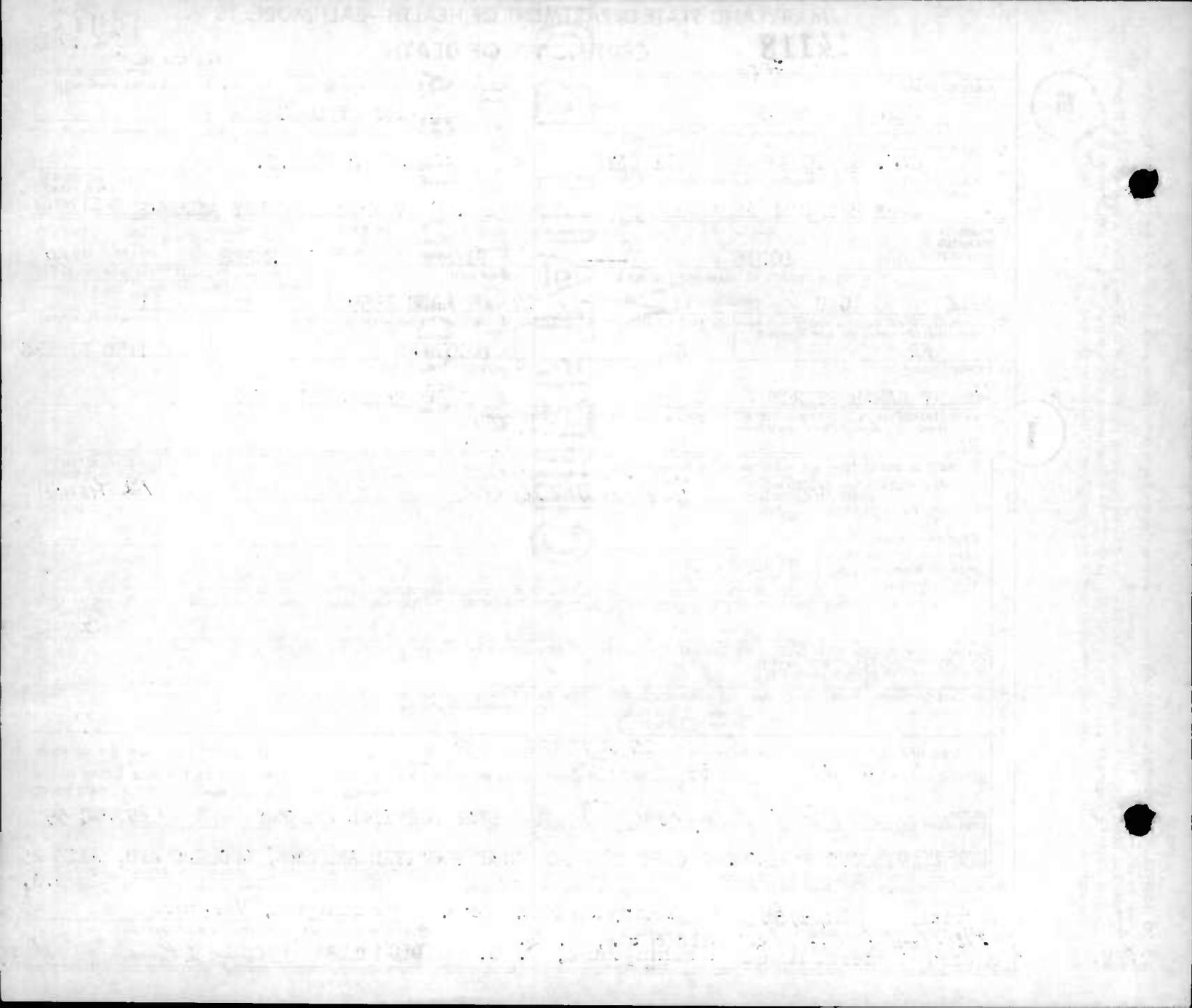
## CERTIFICATE OF DEATH

14071

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD DISTRICT OF COLUMBIA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>		c. LENGTH OF STAY IN 1b <b>11 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X WASHINGTON 25 D.C.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>LOT 47 TRAILER COURT ANDREWS</b>	
3. NAME OF DECEASED (Type or print) <b>LOUIS</b>		First	Middle
		—	Last
4. DATE OF DEATH <b>PIERCE</b>		Month	Day
		<b>DECEMBER</b>	<b>7</b>
		Year	<b>1959</b>
S. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>27 NOVEMBER 1959</b>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NA</b>	10a. KIND OF BUSINESS OR INDUSTRY <b>NA</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>
13. FATHER'S NAME <b>ROBERT LAMAR PIERCE</b>		14. MOTHER'S MAIDEN NAME <b>IRENE ELIZABETH MEYER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NA</b>		16. SOCIAL SECURITY NO. <b>NA</b>	INFORMANT <b>FATHER</b>
17. Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b>	
763.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>12 Hours</b>	
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>27 NOVEMBER</b> , 19 <b>59</b> , to _____, 19_____, that I last saw the deceased alive on <b>7 DECEMBER</b> , 19 <b>59</b> , and that death occurred at <b>1230P</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>7 DEC 59</b>	
ACTUAL SIGNATURE <i>Vincent P Ringrose, Jr.</i>		M.D. <b>USAF HOSPITAL ANDREWS</b>	
PHYSICIAN'S NAME (Type) <b>VINCENT P RINGROSE CAPT USAF MC</b>		USAF HOSPITAL ANDREWS, ANDREWS AFB, WASH 25	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/9/59</b>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Arlington Nat. Cem.</b>	22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Michael J. Rinaldi</i> Rinaldi Funeral Home		24a. ADDRESS <b>816 H St. N. E.</b>	24b. REC'D BY REGISTRAR DATE <b>DEC 10 '59</b>
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

2050362XVI



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14080 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14072

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL <i>Chesapeake</i>		c. LENGTH OF STAY IN 1b <i>Dead at home</i>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE			
<i>Prince George's</i> MARYLAND					b. COUNTY			
				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		d. STREET ADDRESS <i>1409 Towall Road NW</i>		
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince George's General Hospital</i>								
3. NAME OF DECEASED (Type or print)		First <i>Ernest</i>	Middle <i>R</i>	Last <i>Part</i>	4. DATE OF DEATH <i>Dec 2 1959</i>	Month <i>Dec</i>	Day <i>2</i>	Year <i>1959</i>

5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 17 1884</i>	9. AGE (In years last birthday) <i>75 yrs.</i>	IF UNDER 1YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>D.C. Water Dept</i>		11. BIRTHPLACE (State or foreign country) <i>Kansas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		

13. FATHER'S NAME <i>Unknown</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>	Address <i>Rock Creek Rd Hyacinth Strauff Electric City, Md</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		<i>Coronary thrombosis</i>
		<i>Cardiovascular renal disease</i>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
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ACTUAL SIGNATURE <i>James T. Boyd</i>	W.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>Dec 2, 1959</i>
EXAMINER'S NAME (Type) <i>James T. Boyd</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>James T. Boyd</i>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	

22a. BURIAL/CREMATION REMOVAL (Specify) <i>12/5/59</i>	22b. DATE THEREOF <i>12/5/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) <i>Baltimore Rd. Md.</i>
23. FUNERAL/DIRECTOR'S SIGNATURE <i>Cherry Chase Funeral Home</i>	ADDRESS <i>5103 Wisconsin Ave. NW</i>	24a. REC'D BY REGISTRAR <i>Marshall</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kiser</i>
		DATE <i>DEC 7 '59</i>	

MINNESOTA STATE BOARD OF HEATH - SURVEY  
MEDICAL EXAMINER CERTIFICATE OF DEATH

DECEASED PERSON'S NAME: **John C. Johnson**  
DATE OF DEATH: **1968**

AGE AT DEATH:

CAUSE OF DEATH:

Heart Disease     Cancer

DEATH OCCURRED IN:

Marquette Hospital, St. Paul, Minnesota

Under date of **July 1, 1968**, I, **John C. Johnson**, deceased, was admitted to **Marquette Hospital**, St. Paul, Minnesota, where he died on **July 1, 1968**.

I declare that he died of **Heart Disease**. I declare that he died of **Cancer**. I declare that he died of **Stroke**. I declare that he died of **Other**.

Heart Disease  
 Cancer  
 Stroke

At the time of death, he was **68** years old.

REGISTRATION NO. **100000000000000000**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14119

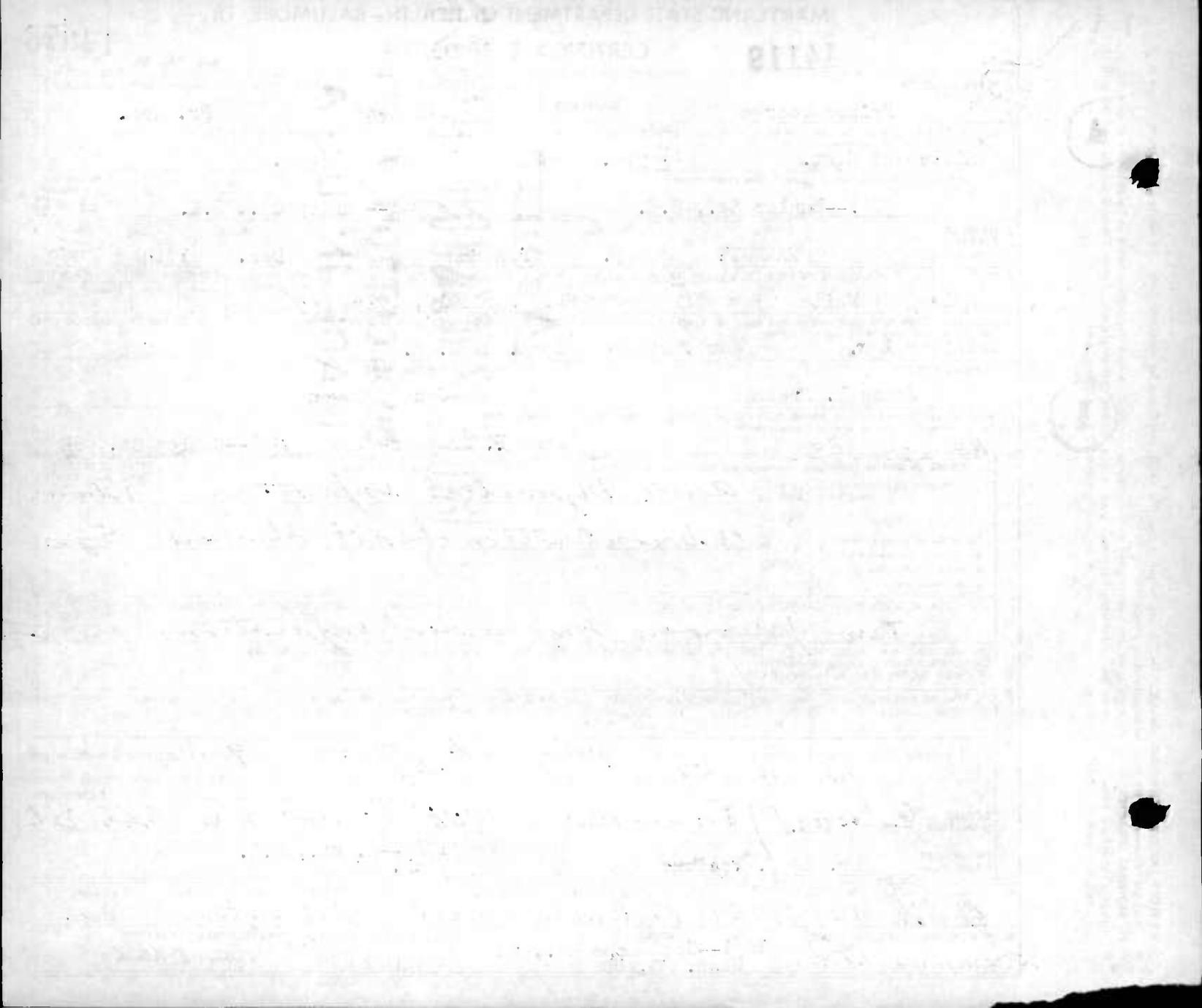
## CERTIFICATE OF DEATH

Reg. Dist. No.

14073

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY  Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Hillcrest Hght.		c. LENGTH OF STAY IN lb 4 $\frac{1}{2}$ yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Hghts.		d. STREET ADDRESS 5041--Dunlap St., S.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5041--Dunlap St., S.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First FRANCIS	Middle F.	Last PRATHER	4. DATE OF DEATH	Month Dec.	Day 17th	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1923	9. AGE (In years lost birthday) 36 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Creditor Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Gulf Discount Corp.		11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James R. Prather				14. MOTHER'S MAIDEN NAME Jane Cowan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. No	INFORMANT		Address Jane B. Prather-Wife 5041--Dunlap St., SE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial infarction</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> DUE TO <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterosclerotic heart disease</i> 5 yrs DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Two previous myocardial infarctions</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1746 K St., N.W.	(County)	(State)	
21. I certify that I attended the deceased from <i>july</i> , 1956, to <i>Nov.</i> , 1957, that I last saw the deceased alive on <i>Nov. 24, 1957</i> , and that death occurred at <i>945 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Edward J. Pacious</i>				ADDRESS (Street, city or town, state) <i>1746 K St., N.W. Wash. D.C.</i>			
PHYSICIAN'S NAME (Type)		Dr. Ed J. Pacious		DATE SIGNED			
22a. BURIAL, CREMATION, REMOVALS (Specify) <i>Burial</i>		22b. DATE THEREOF 12-21-59		22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Natl.</i>		22d. LOCATION (City, town, or county) <i>Arlington Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Semmons Bros.</i>		ADDRESS 1661--Good Hope Rd., SE Wash. 20, DC		24a. REC'D BY REGISTRAR DATE DEC 21 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14120

## CERTIFICATE OF DEATH

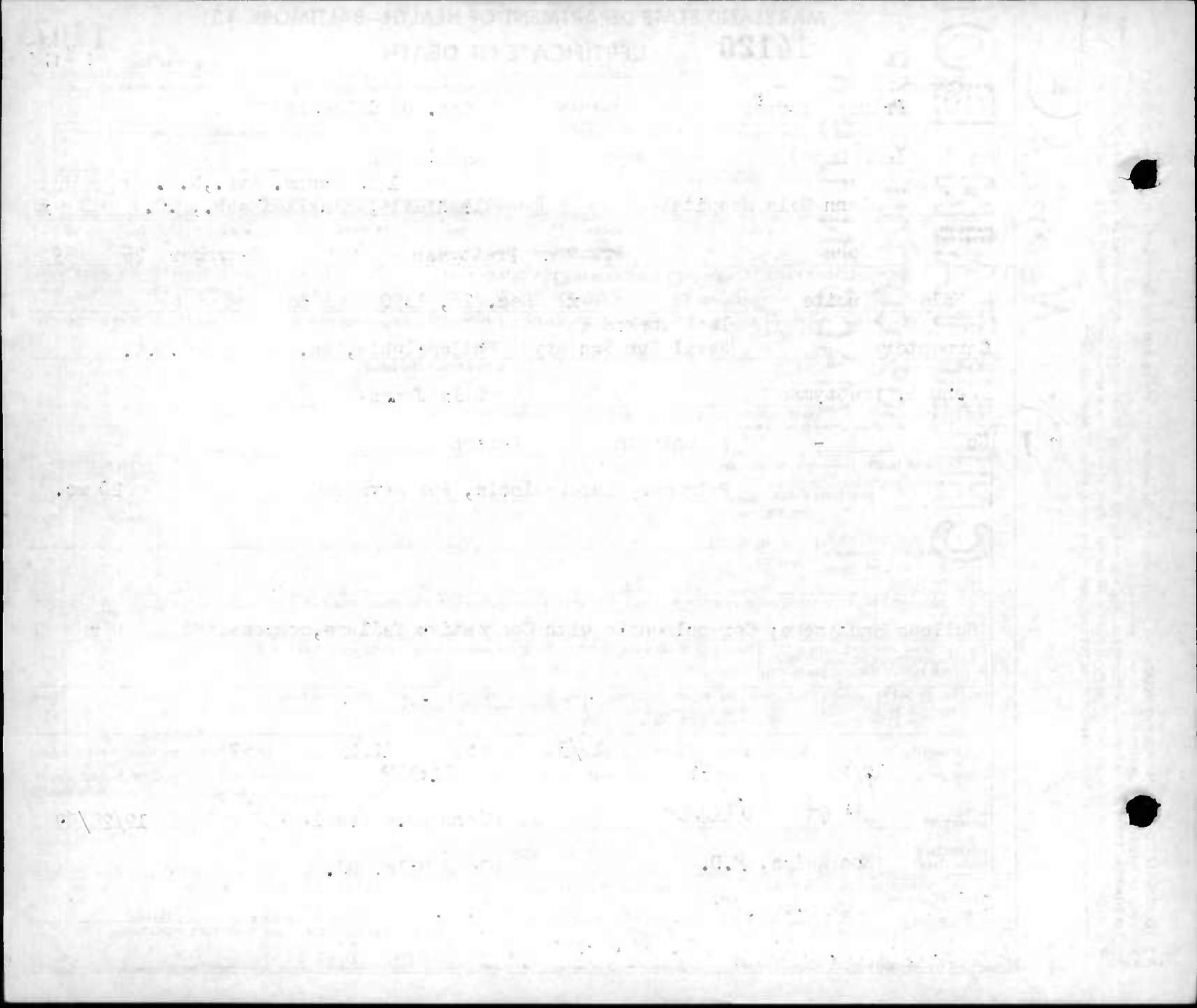
Reg. Dist. No.

14074

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Distr. of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural (Glenn Dale)</b>		c. LENGTH OF STAY IN 1b <b>57 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gleann Dale Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>1766 Penna. Ave., N.W. Glenn Dale, Maryland Wash., D.C.</b>	
3. NAME OF DECEASED (Type or print) <b>John</b>		First <b>Frederick</b>	Middle <b>Jean</b>
Last <b>Prettyman</b>		4. DATE OF DEATH <b>December 25 1959</b>	Month Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 26, 1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. INDUSTRY <b>Last worked at Naval Gun Factory</b>	9. AGE (In years lost birthday) yrs. <b>68</b>
13. FATHER'S NAME <b>John A. Prettyman</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	14. MOTHER'S MAIDEN NAME <b>Ella Jones</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis, Far Advanced</b>		INFORMANT <b>Person</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>20 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bullous Emphysema; Cor pulmonale with Congestive failure, compensated</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on <b>12/25 1959</b> , and that death occurred at <b>12:15 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Moe Weiss</b> <b>12/25/59</b>	
ACTUAL SIGNATURE <b>Moe Weiss</b>		M.D. <b>Glenn Dale Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		Glenn Dale, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-26-59</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cem.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Muller's Sons</b>		22d. LOCATION (City, town, or county) <b>Suitland, Maryland</b>	24a. REC'D BY REGISTRAR <b>DEC 30 '59</b>
		ADDRESS <b>1756 Penna. Wash., D.C.</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14081

Item 7 Film G253 12-16-59 et

Reg. Dist. No.

14075

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>12 hrsn</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Princes Georges General</b>		e. STREET ADDRESS <b>Cheverly</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Sarah</b>	Middle <b>C</b>	Last <b>Reeves</b>
4. DATE OF DEATH	Month <b>Dec.</b>	Day <b>7</b>	Year <b>19 59</b>
5. SEX <b>Negro- Fm.</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-20-80</b>
9. AGE (In years last birthday) <b>79 yrs.</b>	10. IF UNDER 1YEAR Months <b>7</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Ind</b>	
12. CITIZEN OF WHAT COUNTRY? <b>V.S.A</b>			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mary M. Jones aquasco vival</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>142.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Thrombosis of rt. Femoral vein</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO (c) <b>Carcinoma of Parotid Gland</b>			
19. WAS AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b>	DATE SIGNED <b>12-9-59</b>		
EXAMINER'S NAME (Type) <b>Dr. John T. Maloney</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/12/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>John's Cemetery</b>	22d. LOCATION (City, town, or county) <b>Aquasco, Prince George's Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George A. G. Belson Aquasco</b>	ADDRESS <b>George A. G. Belson Aquasco</b>	24a. REC'D BY REGISTRAR DATE <b>DEC 10 1959</b>	24b. REGISTRAR'S SIGNATURE <b>John S. Thomas</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certifying physician by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 3 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
1SM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14082

## CERTIFICATE OF DEATH

Reg. Dist. No.

14076

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Prince /Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b>		d. STREET ADDRESS <b>33 1401-54th Ave</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Julia</b>		First	Middle	Last	4. DATE OF DEATH <b>B. Rhodes</b>	Month	Day	Year
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 - 13 - 13</b>		9. AGE (In years lost birthday) <b>16 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York, N.Y</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Gustav Ey.</b>		14. MOTHER'S MAIDEN NAME <b>Augusta Michael</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>577-01-2689</b>		INFORMANT <b>John T Rhodec -same as above</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rancy fo pewia - Anemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ch. Myelogenous Leukemia</b> DUE TO (c) <b>275.</b>								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Dec 1, 1957</b> , to <b>12-8, 1959</b> , that I last saw the deceased alive on <b>12-8, 1959</b> , and that death occurred at <b>12-8, 1959</b> M, from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>George Hageage M.D. 3717 38th St. N.E. 12-8-59</b>								
DATE SIGNED								
ACTUAL SIGNATURE								
PHYSICIAN'S NAME (Type) <b>Dr. George Hageage</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-11-59</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>		22d. LOCATION (City, town, or county) <b>Ft Myer. Va.</b>		
(State)								
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home - Washington D. C.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>		

5805

100%

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**CERTIFICATE OF DEATH**

Reg. Dist. No. 14077

1. PLACE OF DEATH o. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>4 yrs -</b>													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <b>CLARENCE</b>		First <b>O.</b>	Middle <b>Ringgold</b>												
4. DATE OF DEATH <b>12 27 1959</b>		Month <b>12</b>	Day <b>27</b>	Year <b>1959</b>											
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 26 1876</b>	9. AGE (In years last birthday) <b>83</b> yrs.	10. IF UNDER 1 YEAR Months <b>6</b>	11. IF UNDER 24 HRS. Days <b>23</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. Months <b>0</b>	14. Days <b>0</b>	15. Hours <b>0</b>	16. Min. <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Kent Island Queen Anne's Co Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
13. FATHER'S NAME <b>James B Rugged</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Nelson</b>		Address <b>6811 Annapolis Rd Mrs Elizabeth R Sterry Landover Md</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Mrs Elizabeth R Sterry</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC CONGESTIVE HEART FAILURE</b>															
420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cor pulm. Sclerotic &amp; fibrillat. process.</b> (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Rivendale, Md</b>		(County) <b>Rivendale</b>		(State) <b>Md</b>					
21. I certify that I attended the deceased from <b>Sept 11-15 1959</b> , to <b>12-27-1959</b> , that I last saw the deceased alive on <b>11-15-1959</b> , and that death occurred at <b>12:45 P.M.</b> from the causes and on the date stated above.															
ACTUAL SIGNATURE <b>Albert Roth</b>															
PHYSICIAN'S NAME (Type) <b>Dr. Albert Roth</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 30 59</b>		22c. NAME OF CEMETERY OR GREA <b>Stonewall</b>		22d. LOCATION (City, town, or county) <b>Stonewall Maryland</b>		(State) <b>Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jewell Barton Joff Boston Box, Centreville, Md</b>		ADDRESS <b>Jewell Barton Joff Boston Box, Centreville, Md</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>									

1883.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14121

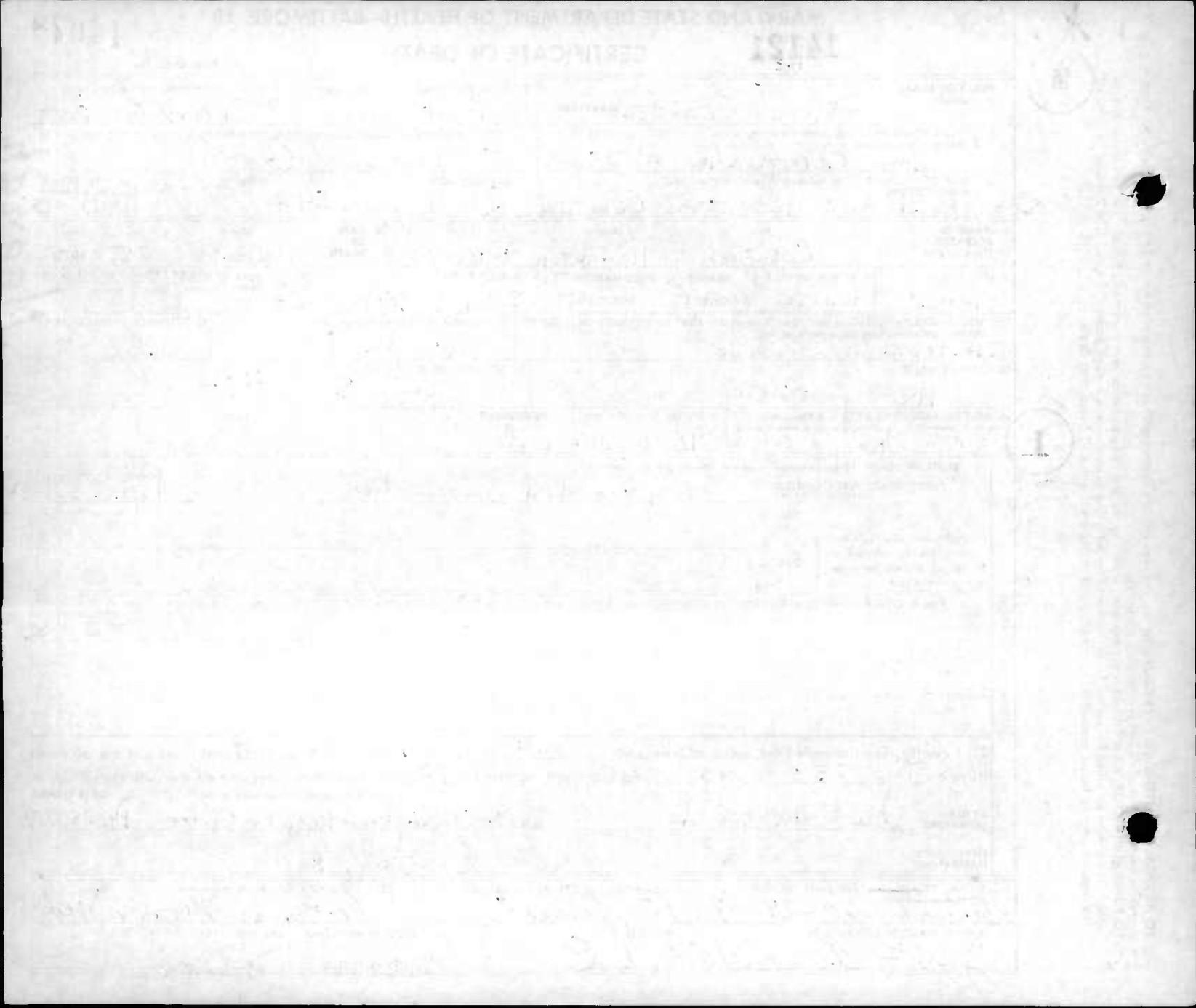
## CERTIFICATE OF DEATH

Reg. Dist. No.

14078

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		MARYLAND		b. COUNTY		PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b RURAL Clinton (Rural) 23 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X Clinton (Rural)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		X So. MARYLAND HOSPITAL CENTER		Rt 2 Box 342							
3. NAME OF DECEASED (Type or print)		First CORBAN	Middle HAMILTON	Last RUDY	4. DATE OF DEATH	December 25	Month	Day	Year		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	JULY 1 1890	9. AGE (In years last birthday)	69 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
MALE		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		Maryland.		12. CITIZEN OF WHAT COUNTRY?		U.S.	
Electrical maintenance											
13. FATHER'S NAME		Henry Rudy		14. MOTHER'S MAIDEN NAME		Alta Schindler		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT							
Yes Navy 1918-1919		265-40-6466 wife-									
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction											
DUE TO 420.1											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Dec 24th, 1951, to Dec 25, 1951, that I last saw the deceased alive on Dec 25th 1951, and that death occurred at 7:00 A.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE David N. Rude											
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, area/county)		(State)			
Burial		12-29-59		St. Lincoln		Colona Manor Md.					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
J. W. Lee - Wash. D.C.											
VS A15 (4) 1SM 9/58				DATE DEC 29 '59		G. L. Knapp					



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



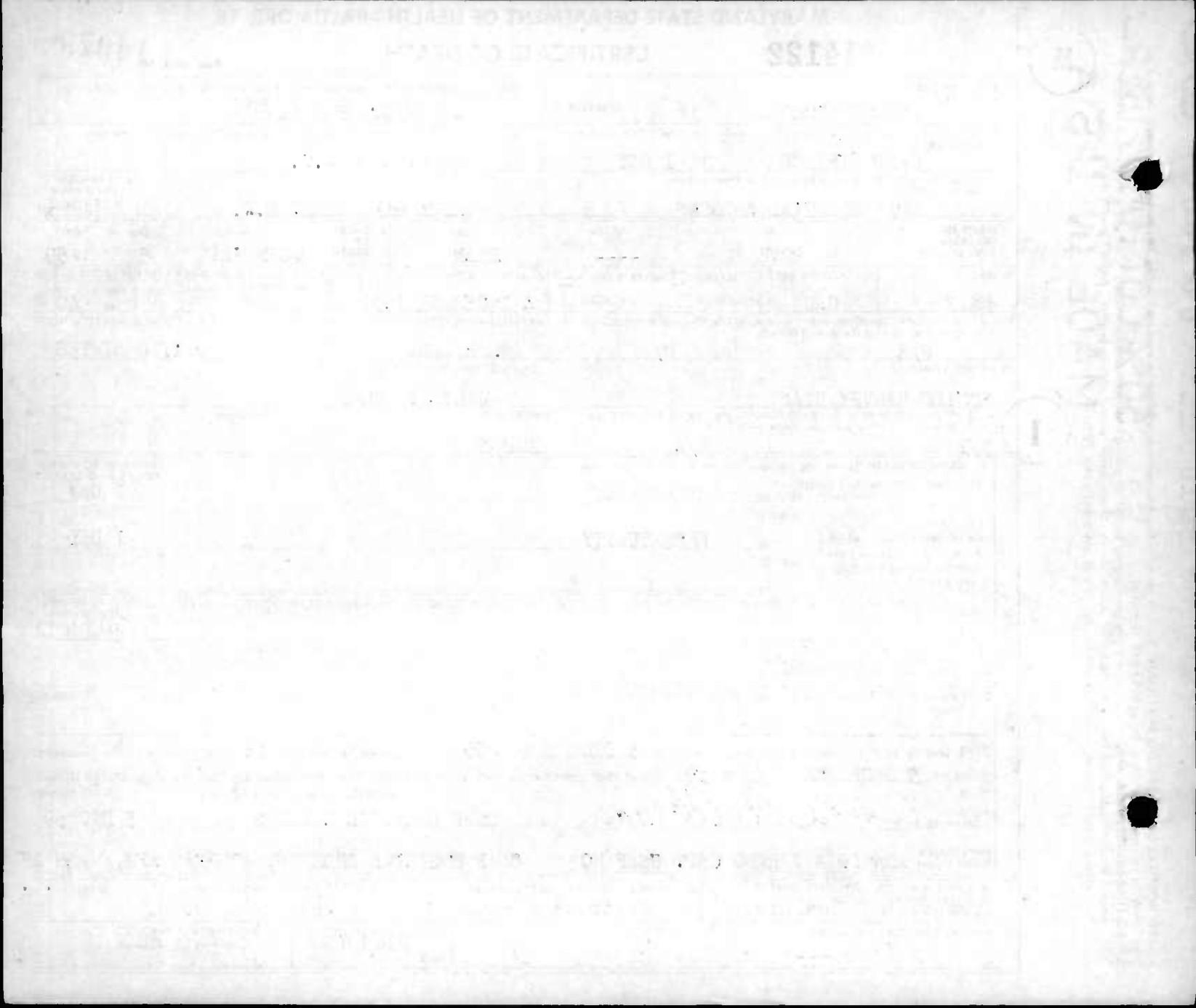
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**CERTIFICATE OF DEATH**

Reg. Dist. No. **14979**

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LOVE</b>		First -----	Middle -----
4. DATE OF DEATH <b>DECEMBER</b>		Last <b>RYAN</b>	Month Day Year <b>5 19 59</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 DECEMBER 1959</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>RONALD HARVEY RYAN</b>		14. MOTHER'S MAIDEN NAME <b>JERILYN STONE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ATELECTASIS</b> DUE TO 762.5 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>PREMATURITY</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While <b>Not while</b> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5 DECEMBER, 1959</b> , to <b>5 DECEMBER, 1959</b> , that I last saw the deceased alive on <b>5 DECEMBER, 1959</b> , and that death occurred at <b>1440PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>ARNOLD A. ABRAMO</b> M.D. <b>USAF HOSPITAL ANDREWS</b> DATE SIGNED <b>5 DEC 59</b>			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>ARNOLD A. ABRAMO CAPT USAF MC</b> USAF HOSPITAL ANDREWS, ANDREWS AFB, WASH 25			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>Not given</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>District Morgue</b>	22d. LOCATION (City, town, or county) <b>Washington, D. C.</b> (State) <b>D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE -----	ADDRESS	24a. REC'D BY REGISTRAR <b>DEC 10 1959</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur J. Tracy</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14084

## CERTIFICATE OF DEATH

Reg. Dist. No.

14080

**TO HOSPITAL** or **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>29 Hr</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Brandywine</b>		d. STREET ADDRESS <b>Rt. 3 Box 234</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Paul</b>	Middle <b>Julius</b>	Last <b>Savoy</b>	4. DATE OF DEATH <b>Dec. 12</b>	Month	Day	Year <b>19 59</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Dec. 11</b>	9. AGE (In years last birthday) yrs. <b>29</b>	IF UNDER 1 YEAR Months <b>29</b>	IF UNDER 24 HRS. Days <b>59</b>	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paul Clements Proctor</b>		14. MOTHER'S MAIDEN NAME <b>Mary Louise Savoy</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>776X</b>		16. SOCIAL SECURITY NO.		INFORMANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 11</b> , 59, to <b>Dec. 12</b> , 19 59 that I last saw the deceased alive on <b>Dec. 12</b> , 19 59, and that death occurred at <b>8P.</b> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Bertha G Van Gelderen, M.D. 3001 Cheverly Ave. Cheverly, Md.</b>							
DATE SIGNED <b>Arthur S. Kraus</b>							
ACTUAL SIGNATURE <b>Bertha G Van Gelderen, M.D.</b>							
PHYSICIAN'S NAME (Type) <b>Bertha G Van Gelderen., M.D.</b>		2001 Cheverly Ave. Cheverly., Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 15, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

STATE GOVERNMENT

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14081

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14085

Item 7 Film G253 12-21-59 et

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i> 10 minutes		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Southland</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Georges General Hospital</i>		e. STREET ADDRESS 14601 - Lewis Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>John</i>	Last <i>Schoepfer</i>
4. DATE OF DEATH	Month <i>Dec</i>	Day <i>12</i>	Year <i>1959</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 9 1894</i>
9. AGE (In years less/birthday yrs.)	10. IF UNDER 1 YEAR Months <i>4</i>	11. IF UNDER 24 HRS. Days <i>10</i>	12. IF UNDER 24 HRS. Hours <i>5</i> Min. <i>30</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Inspector Health Dept</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Health Dept</i>	11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>William John Schoepfer</i>	14. MOTHER'S MAIDEN NAME <i>Amelia Butterworth</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <i>Yes WWI 1917-44-5518</i>	
16. SOCIAL SECURITY NO. <i>47-109-5626</i>		17. INFORMANT <i>Gladys G. Hillman Southland</i>	Address <i>4109-5626</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Cerebral Vascular accident</i> DUE TO (c) <i>Cardiovascular renal disease</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Arlington</i> (County) <i>VA</i> (State) <i>VA</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>James I. Boyd</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>12-12-59</i>
EXAMINER'S NAME (Type) <i>James I. Boyd</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/16/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National</i>	22d. LOCATION (City, town or county) (State) <i>Arlington Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James I. Ayers</i>	ADDRESS <i>317 Pa. Ave. S.E. D.C.</i>	24a. REC'D BY REGISTRAR DATE DEC 16 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

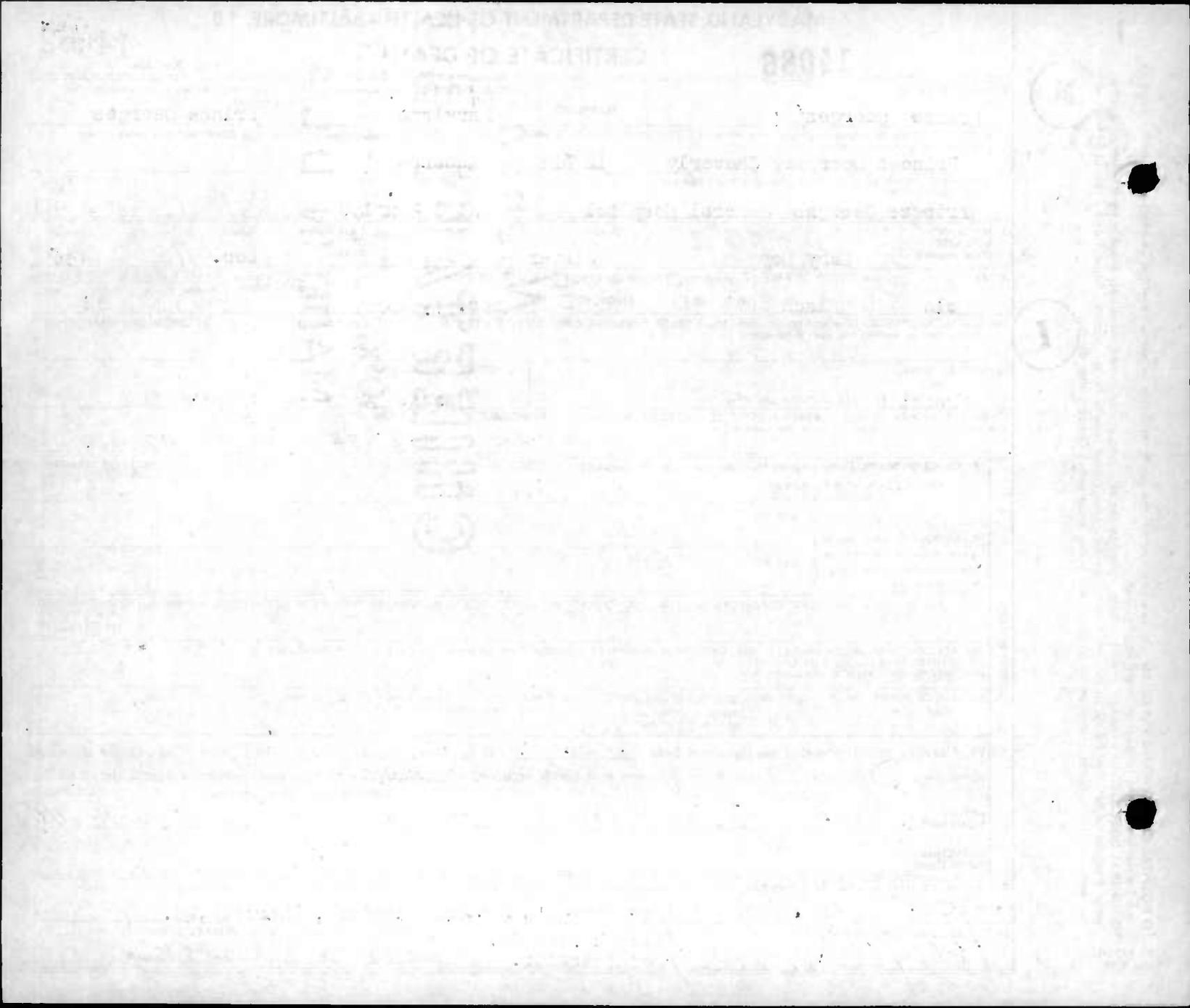
14086

## CERTIFICATE OF DEATH

14082

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princes Georgesz Cheverly</b>		c. LENGTH OF STAY IN lb 12 hrs X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Princes Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Baby Boy</b>	Middle <b>Slater</b>	Last 4. DATE OF DEATH Month <b>Dec.</b> Day <b>7</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1959</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Franklin ALEXANDER</b>		14. MOTHER'S MAIDEN NAME <b>Doris ROSALIE YOUNG</b> Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT <b>MOTHER</b> Box 158 Rt. I AQUASCO	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776 X</b> DUE TO <i>Prematurity</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 7, 1959</b> to <b>Dec. 7, 1959</b> that I last saw the deceased alive on <b>Dec. 7, 1959</b> , and that death occurred at <b>1001</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Busha S. Knapp, M.D.</i>		ADDRESS (Street, city or town, state) <i>3001 Cheverly Ave, Cheverly, Md.</i> DATE SIGNED <i>12/7/59</i>	
PHYSICIAN'S NAME (Type) <i>Say W. Penn</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>12/16/59</b>	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) <b>Prince George's General Hospital, Cheverly, Md.</b> (State)	
23. FUNERAL-DIRECTOR'S SIGNATURE <i>Say W. Penn</i>		24a. ADDRESS <i>Harry W. Penn Jr.</i>	24b. REC'D BY REGISTRAR <b>DEC 21 '59</b>
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG254 1-4-60 et

14087

## CERTIFICATE OF DEATH

Reg. Dist. No.

14083

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>15 Min</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William</b>		First <b>W</b> Middle <b>S</b> Last <b>souder</b>	4. DATE OF DEATH Dec. <b>27</b> Month <b>19</b> Day <b>59</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>July 4, 1878</b>		9. AGE (In years last birthday) <b>81 80</b> yrs.	10. IF UNDER 1 YEAR Months <b>5</b> Days <b>15</b> Hours <b>10</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>WASH D.C.</b>
13. FATHER'S NAME <b>Joseph A Souder</b>		14. MOTHER'S MAIDEN NAME <b>DORA C. Reckeweg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-34-4152</b>	INFORMANT <b>ABbie E. Souder</b>
17. ADDRESS <b>Brentwood M.D.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary occlusion</b> DUE TO (c) <b>arterio sclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> year	
19. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 17 1951</b> , 1951, to <b>Aug 27 1951</b> , 1951, that I last saw the deceased alive on <b>Aug 27 1951</b> , 1951, and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>4314 Fellowship St. Suitland, Md.</b>	
ACTUAL SIGNATURE <b>Til Bergman</b>		DATE SIGNED <b>May 1951</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Til Bergman, M.D.</b>		22d. LOCATION (City, town, or county) <b>Suitland, Md.</b>	
22a. BURIAL CREMATION <b>CREMATION</b>		22b. DATE THEREOF <b>12/30/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home 44 Main Ave NC</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 29 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

W. D. Gandy  
President of the  
National Bank of the  
State of Texas

1803

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 18 Film 254 1-5-60 ams Item 2 Film G254 1-4-60 et 14123 CERTIFICATE OF DEATH												Reg. Dist. No. 14084				
1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>						2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <i>MARYLAND D.C.</i>						b. COUNTY <i>PRINCE GEORGES</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Camp Springs</i>			c. LENGTH OF STAY IN lb <i>2 hrs 14 mins</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MSAF Hospital Andrews</i>			d. STREET ADDRESS <i>3865 Halley Terr. S.E.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>USAF Hospital Andrews AFB</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			f. DATE OF DEATH <i>December 25 1959</i>			Month	Day	Year		
3. NAME OF DECEASED (Type or print)		First <i>SUSAN</i>	Middle <i>K.</i>	Last <i>Staten</i>												
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>25 Dec. 1959</i>	9. AGE (In years lost birthday) yrs. <i>1</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>N/A</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	13. FATHER'S NAME <i>James R. Staten</i>	14. MOTHER'S MAIDEN NAME <i>THEODA K. PALMER</i>	Address	IF UNDER 1 YEAR Months <i>2</i>	IF UNDER 24 HRS. Days <i>14</i>	Hours <i>2</i>	Min. <i>14</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>Hospital Records</i>													
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>560.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Atetangi, congenital</i>												INTERVAL BETWEEN ONSET AND DEATH <i>two hours</i> and <i>14 minutes</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED White Nat white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Byesville, Ohio</i>	(County)	(State)										
21. I certify that I attended the deceased from <i>25 DEC. 1959</i> , to <i>25 DEC. 1959</i> , that I last saw the deceased alive on <i>25 DECEMBER 1959</i> , and that death occurred at <i>5:32 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>John A. Moore</i> PHYSICIAN'S NAME (Type) <i>JOHN A. MOORE, CAPT USAF MC</i>												ADDRESS (Street, city or town, state) <i>USAF HOSPITAL ANDREWS</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/29/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>816 H Street, N. E.</i>	22d. LOCATION (City, town, or county) <i>Byesville, Ohio</i>	(State)											
23. FUNERAL DIRECTOR'S SIGNATURE <i>Michael J. Rinaldi</i>		ADDRESS <i>Rinaldi Funeral Home Washington 2, D. C.</i>	24a. REC'D BY REGISTRAR DATE <i>DEC 28 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Oralia L. Kraus</i>												



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cancellation, or removal.

VS. AISM(E)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1408 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 14085		
1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>P.G. Co.</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>			c. LENGTH OF STAY IN 1b <i>2 1/2 hrs</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Hall</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Georges Gen-Hosp.</i>			e. STREET ADDRESS <i>Boyce Farm.</i>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Kirk Douglas Stevens</i>			First	Middle	Last	4. DATE OF DEATH <i>12-23-1959</i>	Month	Day	Year			
S. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-26-58</i>			9. AGE (In years last birthday) <i>1 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John J. Stevens</i>			14. MOTHER'S MAIDEN NAME <i>Lavinia Johnson</i>			Address <i>Ann J. Stevens same address</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Inanition</i> 790.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____										INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>John T. Maloney</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							DATE SIGNED <i>Dec-23-1959</i>		
EXAMINER'S NAME (Type) <i>John T. Maloney, M.D.</i>			22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Dec. 26/59</i>			22b. DATE THEREOF <i>Dec. 26/59</i>			22c. NAME OF CEMETERY OR CREMATORIAL FACILITY <i>Family &amp; Friends Edenton</i>		22d. LOCATION (City, town, or county) <i>Edenton</i>	(State) <i>N.C.</i>
23. FUNERAL-DIRECTOR'S SIGNATURE <i>J. L. Johnson Amaroles</i>			ADDRESS			24a. REC'D BY REGISTRAR <i>Date Dec 29 '59</i>			24b. REGISTRAR'S SIGNATURE <i>Cathleen S. Koenig</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14124 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14086

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
Prince George's MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Sutherland	6 days	X Camp Springs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Sutherland Nursing Home		5408 - Henderson Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
John	Henry	Stoner	
4. DATE OF DEATH	Month	Day	Year
Dec	26	1957	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White		Aug 6, 1878
9. AGE (In years from birthday to date of death) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. CITIZEN OF WHAT COUNTRY? Hours Min.
81			U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer	Retired	Indiana	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Cyrus Stoner	Sarah Brockens		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		Walcott C. Gibson, Sanitas #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
Cerebral thrombosis			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.			
(b) Cardiovascular renal disease			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> James I. Boyd Dec 26, 1957		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	22d. LOCATION (City, town, or county) (State)
cremated	Dec 30-1959	Xter Side Cemetery 254 Carroll St. - D.C.	Atic - Indiana
23. FUNERAL DIRECTOR'S SIGNATURE	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE	
Arthur Lefever	DEC 30 1959	James S. Hanna	

**EXCERPT FROM THE CHARTER OF THE UNIVERSITY OF TORONTO**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

14088

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince George's Co</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>MARYLAND</i>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oxon Hill Md</i>	c. LENGTH OF STAY IN 1b <i>71 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oxon Hill Md</i>	b. COUNTY <i>prince's Co</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4931-Livingston Road SE</i>	d. STREET ADDRESS <i>4931-LIVINGSTON RD SE</i>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>George</i>	First <i>HERBERT</i>	Middle <i>TALBERT SR</i>	Last <i>Dec. 8th 1959</i>
4. DATE OF DEATH Month <i>Dec.</i> Day <i>8</i> Year <i>1959</i>	5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>MARCH 5-1880</i>	9. AGE (In years last birthday) <i>79 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>	11. KIND OF BUSINESS OR INDUSTRY <i>FARMER</i>
12. BIRTHPLACE (State or foreign country) <i>Oxon Hill, Md.</i>	13. CITIZEN OF WHAT COUNTRY? <i>USA</i>	14. MOTHER'S MAIDEN NAME <i>Annie E Cissel</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>
16. SOCIAL SECURITY NO. <i>5-10-1234</i>	17. INFORMANT <i>SALLIE ANY TALBERT</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>177X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	19. INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>None</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Carcinoma of prostate</i>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Dec 8 1959</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>101 Dudley Lane SE</i>	20f. (City or town) (County) (State) <i>Oxon Hill, Md.</i>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____. ADDRESS (Street, city or town, state) <i>101 Dudley Lane SE</i> DATE SIGNED <i>12/8/59</i>			
ACTUAL SIGNATURE <i>Herbert W. TALBERT</i>	PHYSICIAN'S NAME (Type) <i>HERBERT WISE SKY</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>Dec 11-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Washington National</i>	22d. LOCATION (City, town, or county) (State) <i>Oxon Hill, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sumner Brothers 1661-9d Ridge Rd SE</i>	24a. ADDRESS <i>1661-9d Ridge Rd SE</i>	24b. REC'D BY REGISTRAR <i>DEC 10 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

2S11

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14089

Reg. Dist. No.

14126

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosaryville	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rosaryville (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 1, Upper Marlboro		d. STREET ADDRESS Route # 1, Upper Marlboro, Md.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE THOMAS TAYLOR	First Middle Last	4. DATE OF DEATH December 25th, 1959	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 7th, 1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Prince Georges Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas Marshall Taylor		14. MOTHER'S MAIDEN NAME Mary Ellen Cater	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Maria E. Peters, 602--A--St., N.E.Wash.D.C. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0 DUE TO Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Universal burns of the body (c) DUE TO second and third degree		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was in room that caught on fire	
20c. TIME OF INJURY Month, Day, Year 1:50 p.m. 12-26-1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home Rosaryville Pg - Md
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED 12/26/1959	
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/1959	
22c. NAME OF CEMETERY OR CREMATORIUM St. Thomas Church Cem.		22d. LOCATION (City, town, or county) (State) Croom, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Will Chambers Company 517--11th St. S.E. Wash. DC		ADDRESS	
24a. REC'D BY REGISTRAR DATE DEC 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the State Board of Health.

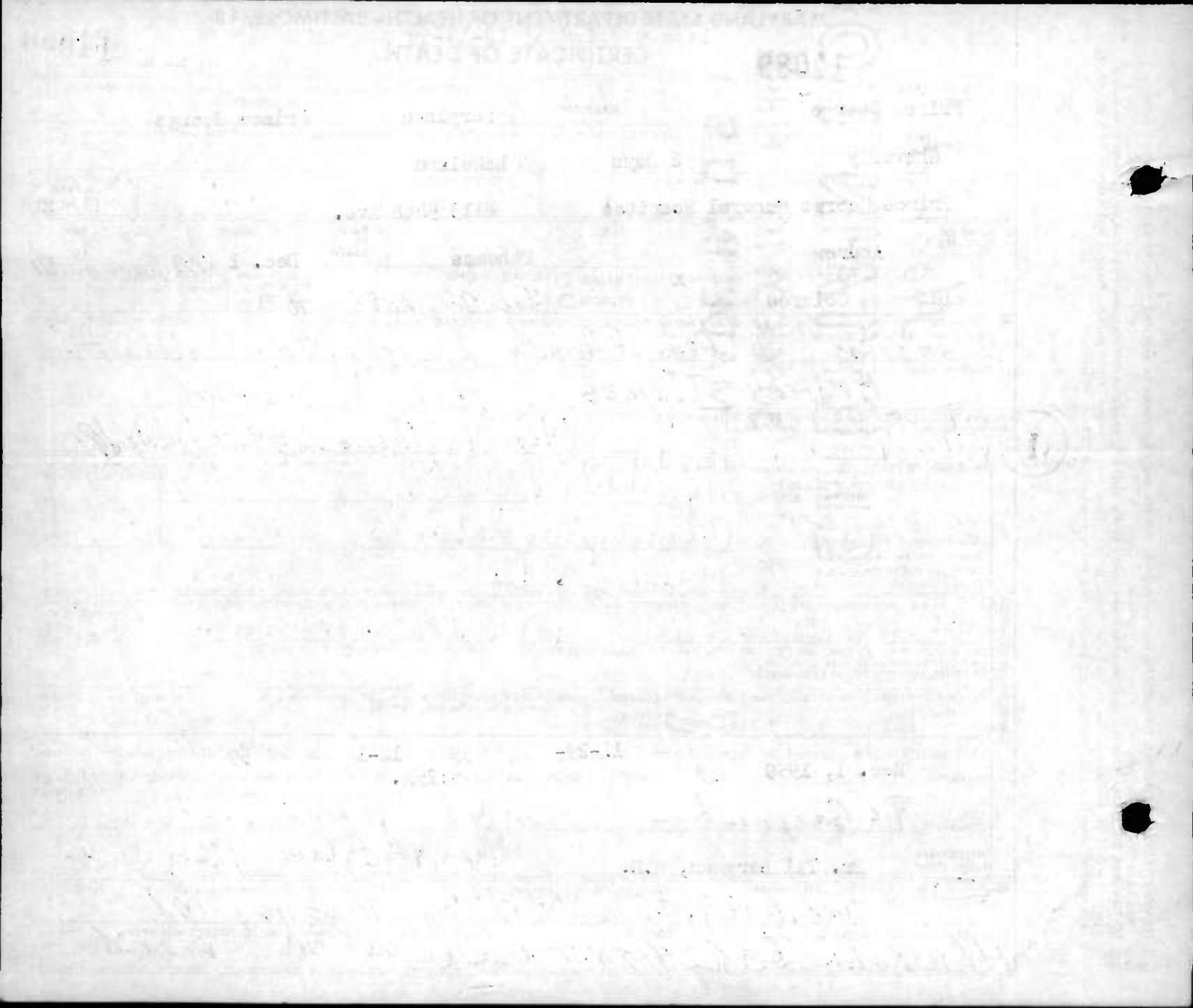
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSM  
5M 2/57



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Item 9 FilmG253 12-14-59 et 14090										
CERTIFICATE OF DEATH										
Reg. Dist. No. _____										
1. PLACE OF DEATH a. COUNTY <b>Prince George</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beverly</b>					c. LENGTH OF STAY IN 1b <b>2 Days</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Andrew</b>	Middle <b></b>	Last <b>Thomas</b>	4. DATE OF DEATH <b>Dec. 1 1959</b>	Month <b>19</b>	Day <b>59</b>	Year <b>59</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 27 1888</b>		9. AGE (In years last birthday) <b>76 yrs.</b>	IF UNDER 1 YEAR <b>Months</b>	IF UNDER 24 MONTHS <b>Days</b>	Hours <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Horticulture</b>			11. BIRTHPLACE (State or foreign country) <b>Laurel, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew</b>			14. MOTHER'S MAIDEN NAME <b>Alice Hebron</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO.			INFORMANT Address <b>Merrill Thomas - 4902 Lakeland Rd.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Myocardial infarction</b>										
INTERVAL BETWEEN ONSET AND DEATH										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>① Encephalomalacia</b> <b>② Bronchopneumonia</b>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>11-29-1959</b>					
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Baltimore</b>	(County) <b>Baltimore</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Dec. 1, 1959</b> , to <b>11-29-1959</b> , to <b>12-1-1959</b> that I last saw the deceased alive on <b>Dec. 1, 1959</b> , and that death occurred at <b>9:25 A.M.</b> from the causes and on the date stated above.										
ACTUAL SIGNATURE <b>Til Bergman</b>					ADDRESS (Street, city or town, state) <b>4319 Bellona St.</b>					
PHYSICIAN'S NAME (Type) <b>Dr. Til Bergman, M.D.</b>					DATE SIGNED <b>Dec. 8 '59</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Dec. 6 1959</b>		22b. DATE THEREOF <b>Dec. 6 1959</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Met. Ch. Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Washington Jr.</b>					ADDRESS <b>467 N St. N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	



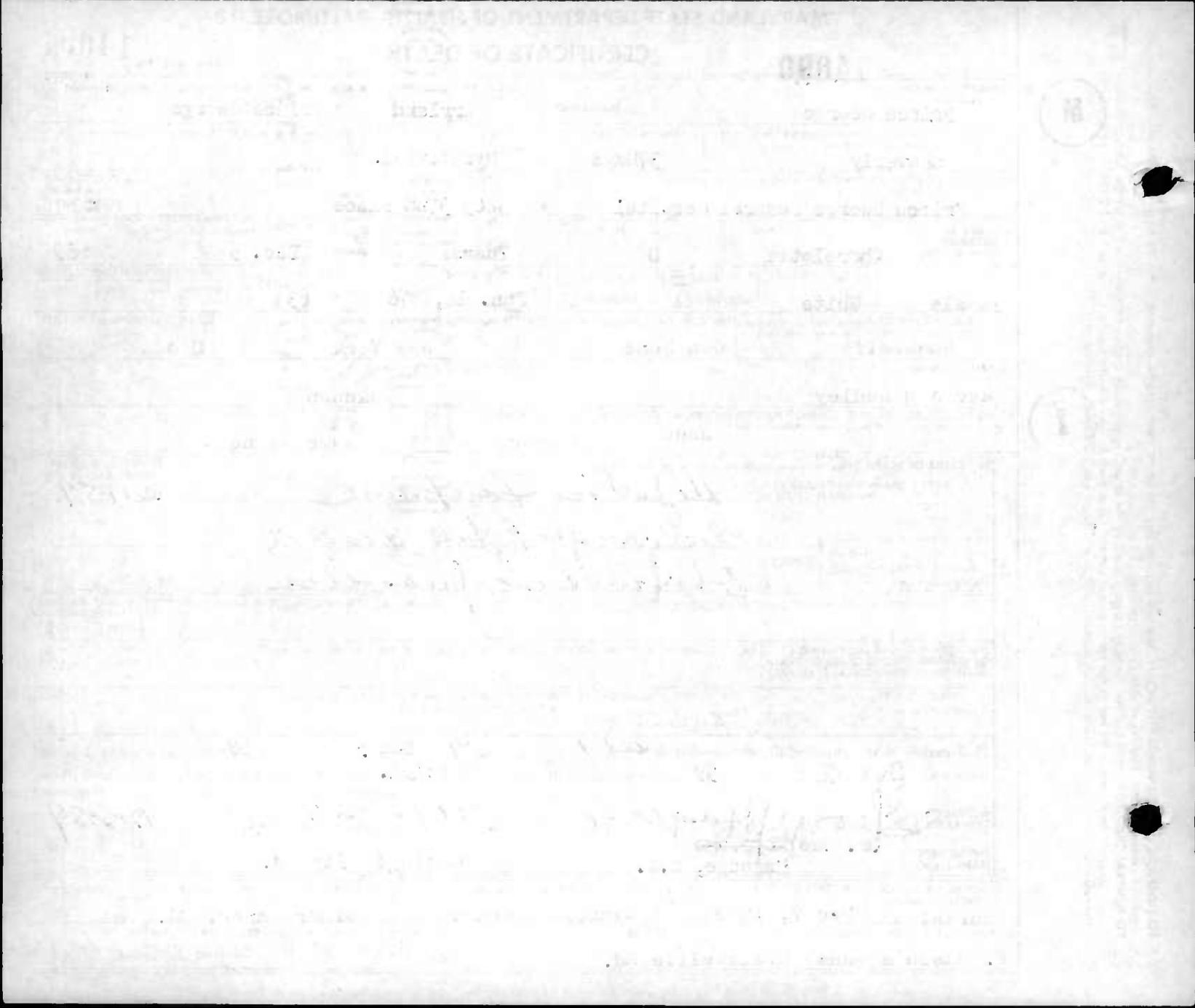
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

14091

14090		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland COUNTY Prince George	
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly 37 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
3. NAME OF DECEASED First Charlotte Middle D Last Thomas		4. DATE OF DEATH Dec. 5 Month Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
10c. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Rev J H Dudley		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none INFORMANT George Thomas Address same as no 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 585x DUE TO Hepatic Failure INTERVAL BETWEEN ONSET AND DEATH Oct 1-59 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) choleangiolytic disease (c) obstructive jaundice			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1, 1959, to Dec 5, 1959, that I last saw the deceased alive on Oct 5, 1959, and that death occurred at 8:15 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Geo Hageage M.D.		ADDRESS (Street, city or town, state) M.D. 3717-38th St. Cottage City Md. DATE SIGNED 12-5-59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 7, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM F't Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE DEC 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

14092

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE					
<i>Prince George</i> MARYLAND		Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
<i>Mt. Rainier</i>	<i>30 yrs</i>	<i>Mt. Rainier</i>	<i>16 Mt. Rainier</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<i>3306 - Otis Street</i>	<i>13306 Otis Street</i>						
3. NAME OF DECEASED (Type or print)	First	Middle	Last				
<i>Walter Sharpe</i>	<i>T</i>	<i>ompkins</i>	<i>Dec</i>				
4. DATE OF DEATH	Month	Day	Year				
	<i>Dec</i>	<i>6</i>	<i>1959</i>				
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH				
<i>M</i>	<i>W</i>	<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>27 Sept. 1885</i>				
9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.					
<i>74 yrs.</i>	Months	Days					
	Hours	Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?				
<i>Painter</i>	<i>Printing</i>	<i>HIGHLAND N.Y.</i>	<i>U.S.</i>				
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	Address					
<i>James Henry Tompkins</i>	<i>Adeline Horx Adams</i>	<i>3306 Cha Rd.</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yr. no. or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH				
<i>No</i>	<i>578-09-0070</i>	<i>Edara E. Manderscheid</i>	<i>4 months</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)							
<i>Carcinoma. lung Mediastinal area</i>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.							
(b) <i>Heavy cigarette smoker for years</i>							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 20d. INJURY OCCURRED p. m. 19 While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <i>July</i> , 19 <i>57</i> , to <i>Oct</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>3 Dec</i> , 19 <i>57</i> , and that death occurred at <i>7:29 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state)							
ACTUAL SIGNATURE <i>Thomas E. Mattingly, M.D.</i> M.D. DATE SIGNED <i>2200 R.T. Ave N.E. 18</i> <i>6 Dec 59</i>							
PHYSICIAN'S NAME (Type)		<i>Thomas E. Mattingly, M.D.</i> DC					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)	
<i>Burial</i>		<i>12/9/59</i>		<i>Fort Lincoln</i>		<i>Colmar Manor, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<i>Nalley's Funeral Home</i>		<i>Mt. Rainier Md.</i>		DATE DEC 10 '59		<i>Arthur S. Kraus</i>	



1

**TO HOSPITAL** or attending physician: The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</b>									
<b>CERTIFICATE OF DEATH</b>									
Reg. Dist. No. 14093									
1. PLACE OF DEATH a. COUNTY      PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      CAMP SPRINGS c. LENGTH OF STAY IN 1b      3 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION      USAF HOSPITAL ANDREWS					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE      Md. (DISTRICT OF COLUMBIA) b. COUNTY      D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      WASHINGTON 27, D.C. d. STREET ADDRESS      6229 MARLBORO PIKE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First LAURENCE	Middle LEE	Last THOMPSON JR	4. DATE OF DEATH	Month DECEMBER	Day 3	Year 1959	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
MALE		CAU	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	30 NOVEMBER 1959	— yrs.	Months 3	Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?
						MARYLAND			UNITED STATES
13. FATHER'S NAME LAURENCE LEE THOMPSON					14. MOTHER'S MAIDEN NAME SUSAN O'ROURKE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO.			INFORMANT CHART			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE      INTERVAL BETWEEN ONSET AND DEATH 773.5      10 MINUTES									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.      (b) PREMATURITY      . 3 DAYS									
DUE TO { (b) (c) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)      20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)      19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Arlington	(County) Virginia	(State)
21. I certify that I attended the deceased from 3 DECEMBER, 1959, to 3 DECEMBER, 1959, that I last saw the deceased alive on 3 DECEMBER, 1959, and that death occurred at 0040A M, from the causes and on the date stated above.									
ADDRESS (Street, city or town, state)      DATE SIGNED									
ACTUAL SIGNATURE      Reginald P McManus M.D. USAF HOSPITAL ANDREWS      3 DEC 59									
PHYSICIAN'S NAME (Type) REGINALD P MCMANUS CAPT USAF MC USAF HOSP ANDREWS, ANDREWS AFB, Wash 25 D.C.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/59		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l. Cem.			22d. LOCATION (City, town, or county) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE Michael J. Rinaldi Rinaldi Funeral Home		ADDRESS 816 H Street, N. E. Washington 2, D. C.		24a. REC'D BY REGISTRAR DATE DEC 7 '59			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

HIAJONG STATIONERY

7511

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

14094

14091

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
Prince Georges MARYLAND		a. STATE Dist. of Col. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Cheverly	4 days	Washington 47X-3							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS							
Prince Georges General Hosp.		230 Rhode Island Ave. N.E.							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First Lee	Middle D	Last Totman	4. DATE OF DEATH	Month December	Day 24,	Year 19 59		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1YEAR	IF UNDER 24 HRS.			
Male	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	July 17, 1876	83 yrs.	Months	Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Retired salesman		Produce		California		U S A			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
John Totman		Charolett Foster							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
--		--		Miss Ariel F. Totman Washington D. C.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock INTERVAL BETWEEN ONSET AND DEATH									
153.8 DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) resection									
DUE TO Surgical procedure for removal of colon									
DUE TO (c) Carcinoma of the colon									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19		While at work <input type="checkbox"/>							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED	
EXAMINER'S NAME (Type)		John T. Maloney, M.D.						December 25, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county)		(State)	
Cremation		12/26/59		Ft Lincoln Crematory		Colmar Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
F. Gasch's Sons		Hyattsville Md.		DATE DEC 28 '59		Arthur S. Krause			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WISCONSIN STATE MEDICAL EXAMINER'S OFFICE  
DEPARTMENT OF HEALTH

Medical Examiner's Report

Case No.

Date

Deceased Name \_\_\_\_\_

Sex \_\_\_\_\_

Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Residence \_\_\_\_\_

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

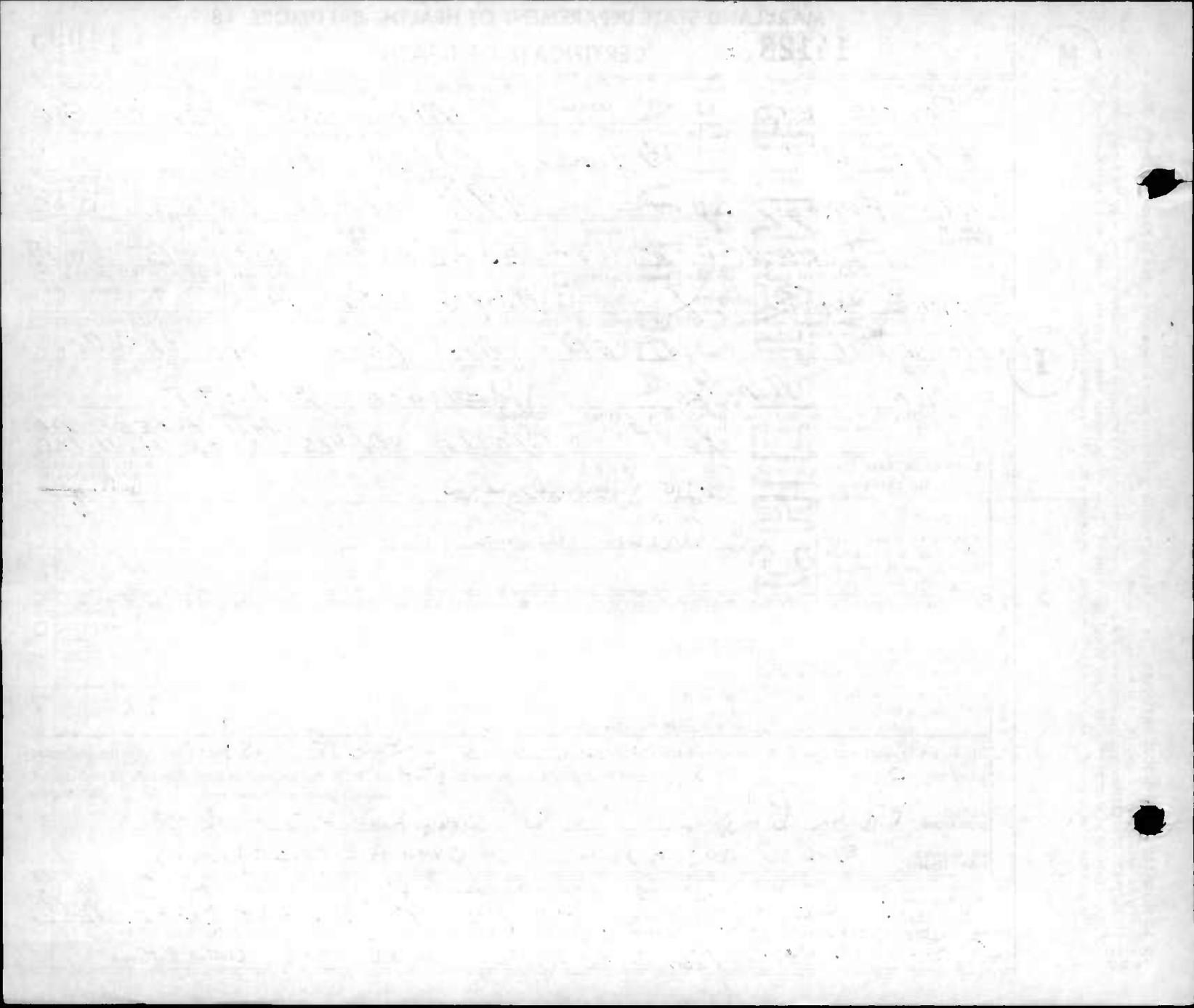
14128

## CERTIFICATE OF DEATH

14095

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>PRINCE Geo.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>OXON Hill</i>		c. LENGTH OF STAY IN 1b <i>22 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4911 FOREST DRIVE</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>FLORENCE-MARTHA-TUCKER</i>		First	Middle
		Last	4. DATE OF DEATH <i>DEC 15 1959</i>
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>MAY 16-1880</i>		9. AGE (In years last birthday) <i>79 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>RETIRED</i>	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Wooten</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Elliott</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE.</i>	
17. INFORMANT <i>STELLA DAVIS</i>		Address <i>4911 FOREST DR. OXON HILL MD.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>33IX</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Cerebral hemorrhage</i>			
(c) DUE TO <i>Arterio-sclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 14, 1959</i> , to <i>Dec 15, 1959</i> that I last saw the deceased alive on <i>Dec 15, 1959</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edwin B. Lane</i>		ADDRESS (Street, city or town, state) <i>5664 LIVINGSTON ROAD</i>	
PHYSICIAN'S NAME (Type) <i>EDWIN B. LANE MD.</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 18-59</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Tucker Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Tucker Dale, N.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>SIMMONS BROS 1661 GOOD HOPE</i>		ADDRESS <i>WASH. D.C.</i>	
		24a. REC'D BY REGISTRAR <i>Arthur S. Thomas</i>	
		24b. REGISTRAR'S SIGNATURE	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14092

## CERTIFICATE OF DEATH

Reg. Dist. No.

14096

1. PLACE OF DEATH o. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>21 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		d. STREET ADDRESS <b>5111 59th Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Frances</b>	Middle	Last <b>Vest</b>	4. DATE OF DEATH	Month <b>Dec. 7</b>	Day <b>19</b>	Year <b>59</b>		
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 1, 1912</b>	9. AGE (In years (Month/Day) <b>46 47 yrs.</b>	IF UNDER 1 YEAR Months <b>16</b>	IF UNDER 24 HRS. Days <b>4</b>	Hours <b>00</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>WHITE STONE VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>RICHARD EDIX</b>		14. MOTHER'S MAIDEN NAME <b>GLADYS POWELL</b>		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		INFORMANT <b>ISAAC M VEST</b>		17. INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic melanoma</b> DUE TO <sup>190.9</sup> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Malignant melanoma</b> DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>13 months</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____, M.D., from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <b>M.D. 3408 Rhode Island Ave</b>	
ACTUAL SIGNATURE <b>Leon R. Leviksy M.D.</b>								DATE SIGNED <b>12/7/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Leon R. Leviksy M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-10-59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>FT LINCOLN CEM</b>		22d. LOCATION (City, town, or county) <b>BLADENSBURG MD</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co</b>		ADDRESS <b>5801 Cleveland Ave</b>		24a. REC'D BY REGISTRAR <b>DEC 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14129

## CERTIFICATE OF DEATH

Reg. Dist. No.

14997

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burton - Adelphi, MD.</i>		c. LENGTH OF STAY IN lb <i>2 yr.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>16 Mt. Rainier</i>		d. STREET ADDRESS <i>4306-31st Street</i>			
d. NAME OF HOSPITAL (If not in Hospital, give street address) OR INSTITUTION <i>Saint Brins Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Elizabeth Caroline</i>		First	Middle	Last	4. DATE OF DEATH <i>Dec. 9</i>	Month	Day	Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 28, 1869</i>	9. AGE (In years lost birthday) <i>90 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Alexandria, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>James W. Nichols</i>		14. MOTHER'S MAIDEN NAME <i>Caroline Faulkner</i>		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Nursing Home Records</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis, Generalized</i> DUE TO <i>450.0</i>						INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Dec 6 1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>7701 Carroll Ave</i>		(County) <i>Takoma Park</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>May 1 1959</i> to <i>Dec 9 1959</i> , that I last saw the deceased alive on <i>Dec 6 1959</i> , and that death occurred at <i>7:20 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>James M. Whitlock M.D.</i> ADDRESS <i>7701 Carroll Ave</i> DATE SIGNED <i>12-9-59</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/12/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Nichols Memorial Cemetery</i>		22d. LOCATION (City, town, or county) <i>Odenton, Md.</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Valleya Funeral Home Inc.</i>		ADDRESS <i>Mt. Rainier, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 14 1959</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57



**TO HOSPITAL** [ ] may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 14093 CERTIFICATE OF DEATH												Reg. Dist. No. 14098											
1. PLACE OF DEATH a. COUNTY <b>Prince George</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>4 Days</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE <b>Maryland</b>				e. COUNTY <b>Prince George</b>							
												c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>											
												d. STREET ADDRESS <b>6006 85th Place</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>Carl</b>		Middle <b>C</b>		Last <b>Weyforth</b>		4. DATE OF DEATH Month <b>Dec.</b>		Day <b>17</b>		Year <b>19 59</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 25, 1888</b>		9. AGE (In years last birthday) <b>71 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. KIND OF BUSINESS OR INDUSTRY <b>Musician</b>		12. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		13. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
14. FATHER'S NAME <b>Robert Weyforth</b>				15. MOTHER'S MAIDEN NAME <b>Elizabeth Holecek</b>				16. SOCIAL SECURITY NO. no				INFORMANT <b>Hospital record</b>				Address <b>Washington D. C.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>586x</b>												<i>Never tire through com</i> <b>123</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>dysrhythmia fibrillation</b> (c) <b>cholesterol coronary</b>												<b>18L</b> <b>2 1/2 days</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from <b>Oct 10, 1959</b> , to <b>Dec. 17, 1959</b> , that I last saw the deceased alive on <b>Dec 17, 1959</b> , and that death occurred at <b>1:35 A.M.</b> from the causes and on the date stated above.												ADDRESS (Street, city or town, state) <b>M.D. 3-D Crescent Road</b> DATE SIGNED											
ACTUAL SIGNATURE <i>Til Bergman, M.D.</i>				PHYSICIAN'S NAME (Type) <b>Dr. Til Bergman</b>								22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>											
												22b. DATE THEREOF <b>Dec 19, 1959</b>				22c. NAME OF CEMETERY OR CREMATORIUM <b>Ft Lincoln Crematory</b>				22d. LOCATION (City, town, or county) <b>Colmar Manor, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville Md.</b>								24a. REG'D BY REGISTRAR DATE <b>DEC 23 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

1900

CERTIFICATE OF REGISTRATION

1946

REGISTRATION

14130

## **CERTIFICATE OF DEATH**

**Req. Dist. No.**

14099

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/5B

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>3 yrs. 11 months, &amp; 11 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>47 X-3</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>				d. STREET ADDRESS <b>328 6th St., S. E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Sarah</b>		First <b>E.</b>	Middle <b>Whitehead</b>	Last <b>Whitehead</b>	4. DATE OF DEATH <b>12</b>	Month <b>12</b>	Day <b>20</b>	Year <b>19 59</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>1/7/1872</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 24 FIRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John K. Bailey</b>				14. MOTHER'S MAIDEN NAME <b>Ada Grimes</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Decedent</b>		Address <b>-</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o.) <b>Pulmonary tuberculosis, far advanced</b> DUE TO 002 X Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs.,</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>(County)</b>		(State)
21. I certify that I attended the deceased from <b>1/6/1956</b> to <b>12/20/1959</b> , that I last saw the deceased alive on <b>12/20/1959</b> , and that death occurred at <b>3:55 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>John Weiss</b> M.D. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>								
ADDRESS (Street, city or town, state) <b>Glenn Dale Hospital</b> DATE SIGNED <b>12/20/59</b>								
22a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-22-59</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>CONGRESSIONAL CEMETERY</b>		22d. LOCATION (City, town, or county) <b>WASHINGTON D.C.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Michael L. Weiss</b>		ADDRESS <b>RINALDI FUNERAL HOME 816 H ST NE, WASH. D.C.</b>		24a. REC'D BY REGISTRAR <b>DEC 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>		

081

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14160

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Baltimore County</i>		<i>Baltimore</i>		<i>26 years</i>		<i>Maryland</i>		<i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS			
<i>4715 1/2 Summer Rd</i>						<i>14715 1/2 Summer</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
<i>Joseph Myles Williams</i>					<i>Dec 13</i>	<i>Dec</i>	<i>13</i>	<i>1959</i>	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
<i>Male</i>		<i>White</i>	<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>Dec 11, 1883</i>	<i>76 yrs.</i>	Months	Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
<i>Skilled Laborer</i>		<i>Railway Express</i>		<i>District of Columbia</i>		<i>U. S. A.</i>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address					
<i>John D. Williams</i>		<i>Irene Cooper Smith</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
<i>No</i>		<i>None</i>		<i>None</i>		<i>Acute congestive heart failure</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <i>Cardiovascular renal disease</i>							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>James T. Boyd</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <i>Dec 13, 1959</i>	
EXAMINER'S NAME (Type) <i>James T. Boyd</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/16/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) <i>Baltimore Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Jr.</i>		ADDRESS <i>517 11th St. N.E.</i>		24a. REC'D BY REGISTRAR DATE DEC 17 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

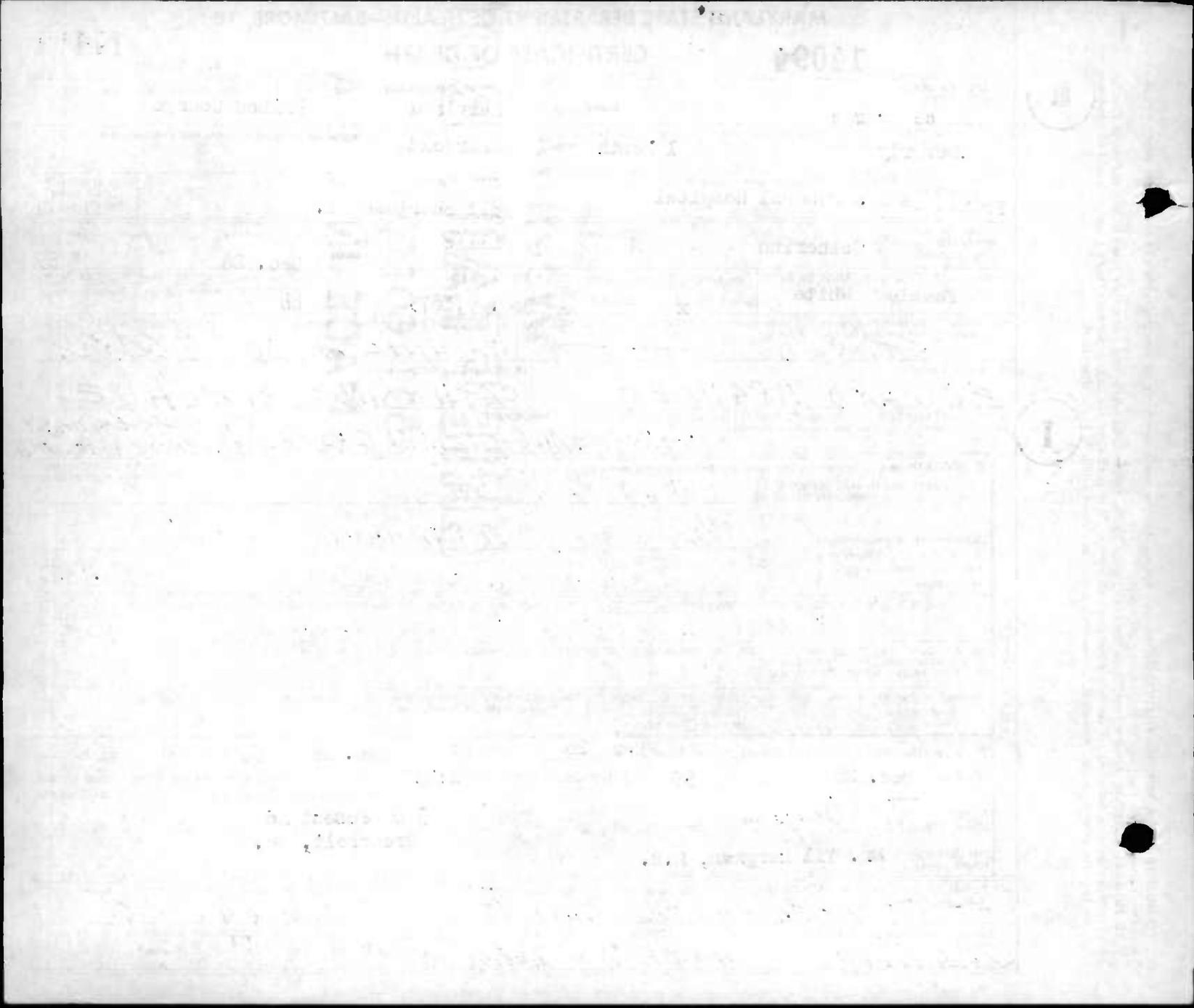
14094

## CERTIFICATE OF DEATH

14101

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		<b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 Month</b>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seabrook</b>		e. STREET ADDRESS <b>9511 Sheridan St.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>9511 Sheridan St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Catherine</b>		First	Middle	Willis	Last	4. DATE OF DEATH <b>Dec. 26</b>	Month	Day	Year <b>19 59</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1875</b>		9. AGE (In years lost birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>EDWARD BRAHLER</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE DONOHUE</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>578-48-5894</b>		INFORMANT <b>MRS. THELMA GRANE</b>		Address <b>9511-SHERIDAN ST SEABROOK ACRES MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>433.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Pulmonary embolus</b> (c) <b>Thrombosis of right auricular appendage</b> DUE TO DUE TO DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 26</b> , 19 <b>59</b> , to <b>Dec. 26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec. 26</b> , 19 <b>59</b> , and that death occurred at <b>1:15 P.M.</b> from the causes and on the date stated above.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
ACTUAL SIGNATURE <b>T. Bergman</b>				M.D.		ADDRESS (Street, city or town, state) <b>3 D Crescent Rd Greenbelt, Md.</b>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Dr. Til Bergman, M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify)- <b>12/30/59</b>		22b. DATE THEREOF <b>12/30/59</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Marys</b>		22d. LOCATION (City, town, or county) <b>Washington D.C.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Baffell</b>		ADDRESS <b>475-H N.W. Wash. D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14095

## CERTIFICATE OF DEATH

Reg. Dist. No.

14102

**TO HOSPITAL OR ENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
15M 9/58

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>		c. LENGTH OF STAY IN 1b <i>3 yrs. /m. Ida</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Laurel Sanitarium</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mattie C. Wilson</i>		4. DATE OF DEATH <i>Dec. 25 1959</i>	Month Day Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>July 10, 1878</i>		9. AGE (In years last birthday) <i>81</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Granville-S. Carolina</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>John H. Coursey</i>	
14. MOTHER'S MAIDEN NAME <i>Lucinda Cook</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>SON</i>		17. INFORMANT <i>John J. Wilson - 2737 Devonshire Place N.W. - Washington - D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Atrial fibrillation</i> (c) <i>Cerebral arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>75 min.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov. 24, 1959</i> , to <i>Dec. 25, 1959</i> that I last saw the deceased alive on <i>Dec. 23, 1959</i> , and that death occurred at <i>10:45 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Laurel Sanitarium</i>	
ACTUAL SIGNATURE <i>Jesse C. Coggins M.D.</i>		DATE SIGNED <i>12/25/59</i>	
PHYSICIAN'S NAME (Type) <i>Jesse C. Coggins - M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/28/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Rock Creek Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D. C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. J. Hines Co 2901-14th St. N.W. Laurel</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 28 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

1902



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14132

## CERTIFICATE OF DEATH

Reg. Dist. No.

14103

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>		c. LENGTH OF STAY IN 1b <b>11 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, DC</b> 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>				d. STREET ADDRESS <b>607 BRANDEYWINE STREET, SE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>MARGARET</b>	Middle <b>B</b>	Last <b>YESULAITIS</b>	4. DATE OF DEATH Month <b>DECEMBER</b>	Day <b>15</b> Year <b>1959</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>9 SEPTEMBER 1882</b>	9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. 
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>LITHUANIA-RUSSIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>					
13. FATHER'S NAME <b>JOHN BALANDA</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		Address <b>706 BRANDYWINE STREET, WASHINGTON, DC</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>JOHN F YESULAITIS (SON)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  420.0		CONGESTIVE HEART FAILURE WITH INFARCTION		INTERVAL BETWEEN ONSET AND DEATH DAYS 	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 		DUE TO ARTERIOSCLEROTIC HEART DISEASE		20 YEARS	
DUE TO (c) 					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m.                          19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4 DECEMBER 1959</b> , to <b>15 DECEMBER 1959</b> , that I last saw the deceased alive on <b>15 DECEMBER 1959</b> , and that death occurred at <b>0200 A.M.</b> , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state)					
DATE SIGNED <b>15 DECEMBER 59</b>					
ACTUAL SIGNATURE <i>John F Bridgeman</i> M.D. USAF HOSPITAL ANDREWS					
PHYSICIAN'S NAME (Type) <b>JOHN F BRIDGEMAN, CAPT, USAF, MC</b> USAF HOSPITAL ANDREWS, WASHINGTON 25, DC					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-19-59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St Joseph's</b>	
22d. LOCATION (City, town, or county) <b>Summit Hill Pa</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Mattingly, 131 - 11th St., S.E.</b>		ADDRESS <b>Washington 3, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 18 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01-3500178-B-011411 TO THIS TRADE STATE ONLY 2AM

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A1S (4)  
15M 9/58

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
Items 11 & 12 Film G253 12/24/59 iwk  
**CERTIFICATE OF DEATH** 14104

**Reg. Dist. No.**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ritchie</b>		d. STREET ADDRESS <b>7137 Whitehouse Rd</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>Arthur</b>	Last <b>Young</b>	4. DATE OF DEATH Dec. <b>14</b> 19 <b>59</b>	Month Day Year		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 June 1881</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Dofs <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS Months <b>0</b> Dofs <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Young</b>		14. MOTHER'S MAIDEN NAME <b>Pricilla</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT <b>Mary Young</b>		Address <b>7137 Whitehouse Rd. Ritchie, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chemical</b> DUE TO <b>610X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute pyelonephritis with abscess formation</b> (c) <b>Prostatic hypertrophy</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <b>Not</b> while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-14</b> , 19 <b>59</b> , to <b>12-14</b> , 19 <b>59</b> that I last saw the deceased alive on <b>12-14</b> , 19 <b>59</b> , and that death occurred at <b>5:00A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Louis B. Backrach, M.D.</i>		ADDRESS (Street, city or town, state) <b>915 - 19th Street, N.W. Washington, D. C.</b>		DATE SIGNED <b>12/14/59</b>			
PHYSICIAN'S NAME (Type) <b>Louis B. Backrach, M.D.</b>		22b. DATE THEREOF <b>12/19/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Simon</b>		22d. LOCATION (City, town, or county) (State) <b>Croome, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Stewart #3081 st. n.e.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 17 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Carrie S. Thomas</i>	

RECOM

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